PSYCHOLOGICAL DISTRESS AND SOCIAL SUPPORT IN BEREAVEMENT: A NURSING INVESTIGATION OF MIDDLE AGED NEWFOUNDLAND WIDOWS

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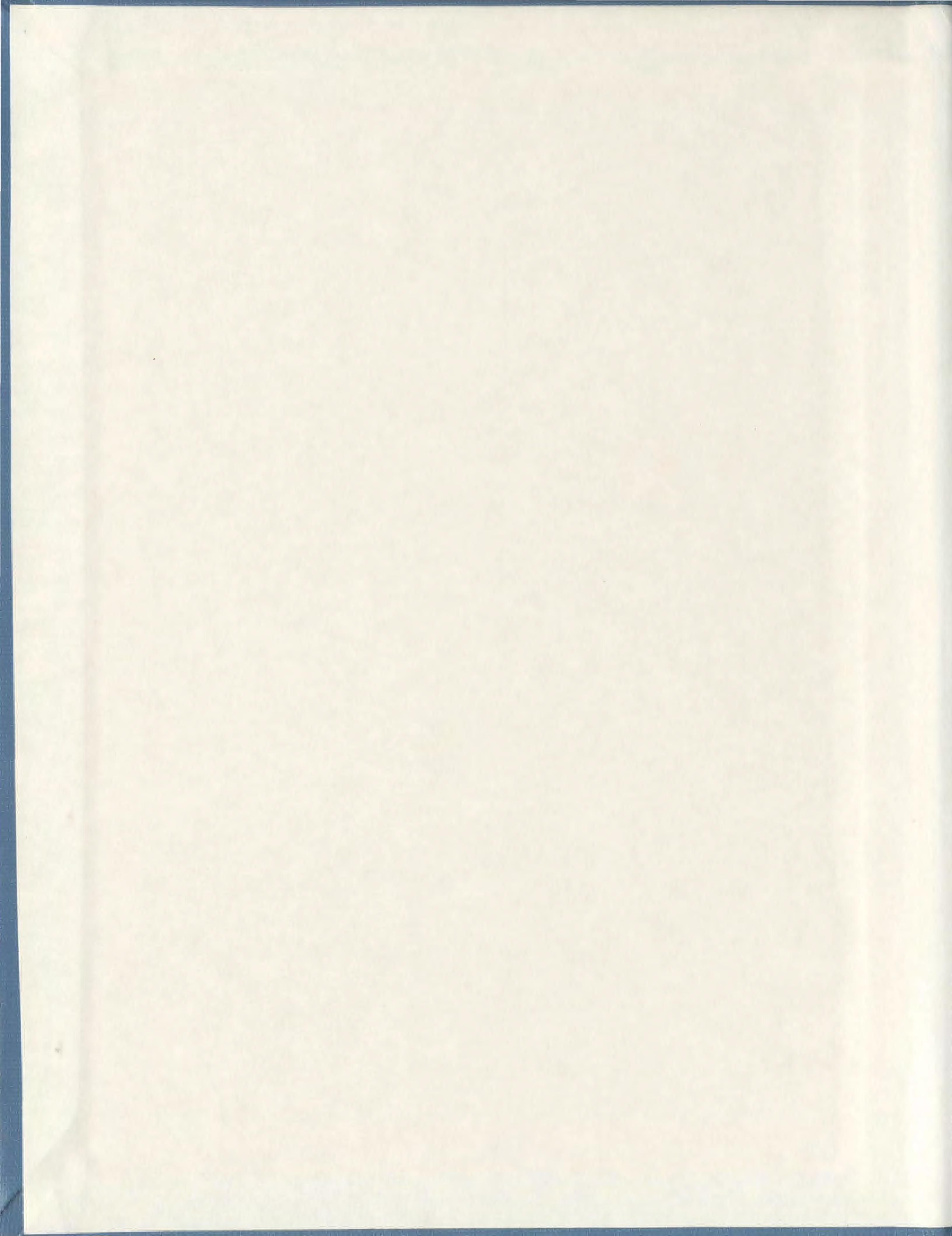

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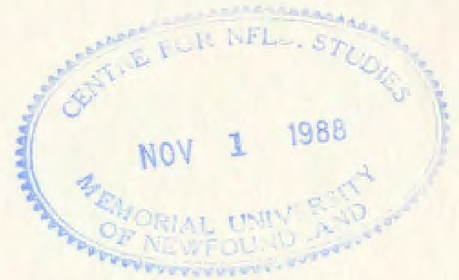

PSYCHOLOGICAL DISTRESS AND SOCIAL SUPPORT IN BEREAVEMENT: A NURSING INVESTIGATION OF MIDDLE AGED NEWFOUNDLAND WIDOWS

© Kathryn Ann Corkery Hustins, B.N.

A thesis submitted to the School of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Nursing

School of Nursing
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St. John's, Newfoundland

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ABSTRACT

Psychological Distress and Social Support in Bereavement:
A Nursing Investigation of Middle-aged Newfoundland Widows

The purpose of this investigation is to describe a sample of middle-aged Newfoundland widows and to determine the nature of a relationship between psychological distress and social support during the first year of bereavement. The sample is 30 women aged 45-64 whose husbands had died within a seven month period. During the first year of bereavement, two interviews are conducted.

Psychological distress is measured using the 30 item Goldberg General Health Questionnaire. A score of 5 or more is taken to indicate psychological distress. The women's psychological distress scores decrease from Interview I ($\bar{x}$ 6.4) to Interview II ($\bar{x}$ 2.6). Three groups of women are identified at the end of the first year of bereavement: those women who report high psychological distress scores throughout the first year of bereavement (n = 4), those women who report low psychological distress scores throughout the first year of bereavement (n = 14), and those women who have initial high psychological distress scores which decrease to low psychological distress scores by the end of the first year of bereavement (n = 11).

Two dimensions of social support, perceived social support network and perceived functional social support, are measured using the Norbeck Social Support Questionnaire. The scores on perceived social support network increase from Interview I ($\bar{x}$ 124.27) to Interview II ($\bar{x}$ 130.50). The scores on perceived functional social support also increase from Interview I ($\bar{x}$ 235.90) to Interview II ($\bar{x}$ 251.90). There is a positive significant statistical correlation between perceived social support network and perceived functional social support at each interview and between interviews. There is no significant statistical correlations between psychological distress and social support during the first year of bereavement. The women in the sample identify family and friends as their main sources of social support.

The author constructed Widow Interview Guides (I and II) provides a description of the background and personal characteristics, the physical and psychological health characteristics and the social characteristics of the widow and a description of the widow's perceptions of the first year of bereavement and the problems and difficulties she encounters. The women in the sample state that loneliness is their most serious problem. Many of the women report difficulty with sleeping, and for some of the women this continues throughout the first year of bereavement.

Case studies integrate some of the major findings and provide a comprehensive view of the Newfoundland widow's first year of bereavement. Recommendations for nursing practice, research and theory are presented.

ACKNOWLEDGEMENTS

> The highest reward for man's toil is not what he gets for it but what he becomes by it.
>
> John Ruskin

I would like to first acknowledge with gratitude the willingness of the women in this study who shared their thoughts, feelings and experiences with me at a very emotional period of their lives. As a result of this experience with these women, I have been affected both personally and professionally.

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I would like to express my appreciation to Ann Morris for her patience and cooperation in typing the many drafts of this thesis.

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CHAPTER I

PROBLEM AND PURPOSES

Introduction

Throughout the course of a woman's life there are many transitions. Some of these transitions are usually anticipated and chosen; education and career directions, marriage, child bearing and divorce, for example. Other transitions may be anticipated but not necessarily chosen; the dissolution of marriage through widowhood with its resulting consequences is one such transition.

Surviving one's spouse (widowhood, generically) has generally been recognized as one of the major events in the life course of married persons. It has been rated as being one of life's greatest stressors (Vachon & Rogers, 1984). This event which can be characterized as a major role transition is more likely to be experienced by women than by men, because of the greater life expectancy of women and because of their tendency to marry men older than themselves (Martin Matthews, 1980). Widowhood has become a stage of life for women in our society.

Today in Canada 82% of widowed persons are widows. While it is not generally anticipated that spousal bereavement will occur before one is elderly and retired, a large number of women in Canada experience what may be perceived as untimely bereavement. Thirty-seven percent of widows are under 65 years of age (Statistics Canada, 1981).

Nurses have consistently stated that providing psychological support for patients is one of the functions of the profession. Because of nurses' involvement with patients at all stages of life and death, it seems natural and appropriate to investigate the phenomena of bereavement. In doing so, nurses can contribute to the body of knowledge in nursing in a meaningful way and share this knowledge with other disciplines so that the quality of life will be enhanced for all individuals.

Problem Statement

Research during the past 20 years has documented a positive relationship between major events and psychological distress (Thoits, 1982). Loss of a spouse has been identified as one of the most stressful of life events and the single most disruptive crisis of all transitions in the life cycle. (Holmes & Rahe, 1967; McFarlane et al., 1980). A widow is not only faced with loneliness, loss of companionship and unmet sexual needs but lacks the comfort, information and support of a partner of many years (Parkes, 1972).

Individuals in the early stages of bereavement experience considerable psychological distress (Clayton, 1973; Parkes & Brown, 1972). Early psychological distress is a major mental health risk factor for the bereaved (Clayton et al., 1972). Variables, separately and in combination, such as low socioeconomic status, husband's sudden death, multiple life crisis and reactions of psychological distress, yearning,

anger and self-reproach at 1 month were predictors of poor outcome at 13 months (Parkes, 1975; Vachon, 1979).

Within the past 15 years, several investigators have hypothesized that the individual's social support system may help moderate or buffer the effects of life events upon his/her psychological state (Antonovsky, 1974; Antonovsky, 1979; Caplan, 1974; Cassel, 1976; Cobb, 1976; Henderson et al., 1978; Kaplan et al., 1977; Liem & Liem, 1978; Thoits, 1982). This is termed the buffering hypothesis: individuals with a strong social support system should be better able to cope with major life events; those with little or no social support may be more vulnerable to life changes, particularly undesirable ones. Hamburg et al. (1982) acknowledged the mediating effects of social support on promoting health. The authors suggest that coping may be affected by the availability and quality of support. The overall effects of social support on stress related to major life events and health in general, however, remain a point of controversy in the literature (Thoits, 1982).

Many investigators of social support have failed to acknowledge the multi-dimensionality of the support concept (Thoits, 1982). Structural properties (e.g. size and composition) of the network of persons providing support, functional properties of the network such as the intensity of support provided and the perceived quality of support received are

suggested by Lenz, Parks, Jenkins and Jarrett (1986) to be conceptually distinct.

Kahn and Antonucci (1980) indicated that the need for social support may be heightened when any one of a person's life roles undergoes a change, especially unwanted and unpredicted change (p. 265). Of all the models that purport to describe the phenomenon of social support in response to a life role change, Kahn and Antonucci's (1980) concept of social support which examines two separate components of social support (e.g. social support network and functional social support) was found to be comprehensive for exploring the response to the loss of a spouse during the first year of bereavement.

Studies of bereavement have indicated that social support systems have a crucial part to play at all stages in adaptation to bereavement (Maddison & Walker, 1967; Vachon et al., 1982). Most bereavement studies have dealt with large urban populations (e.g. London, Boston, St. Louis, Sidney, Toronto). Only one study was found that considered the combined factors of social support, psychological distress and physical responses to bereavement in a middle-aged population (Vachon, 1979). Moreover, the one study in Newfoundland (Robertson, 1979) was not designed to show the true prevalence of psychological, social and physical problems in response to a loss of spouse, rather it documented types of problems and resources that might be useful.

Significance of Investigation

Although widowhood is a possible consequence of marriage, few women are prepared for it. Most of the research done in the area of widowhood conceptualizes this life event as a role loss, or as a form of role exit from role of wife to the role of widow. A more recent development in the field is the recognition that widowhood for many women is far more than a loss of role. It undermines the basis of the widow's identity and sense of self. When someone dies, very often the meaning seems to go out of the lives of those with whom the deceased person was most intimately involved.

> The person on whom so many purposes turned, to whom so many pleasures, conflicts, anxieties related, is suddenly gone. Bereavement presents unambiguously one aspect of social changes- the irretrievable loss of the familiar (Marris, 1974, p. 23).

With the above potential changes and stresses, it is assumed that the bereaved individual needs to have the support of significant others while beginning the transition into the role of being a widowed person. Unfortunately, an individual's process of grieving, change in role and possible corresponding decrease in status may simultaneously pose a threat to the significant others to whom the individual is most strongly tied, and these potential helpers may begin to withdraw within a short period of time. This withdrawal occurs in part because of the discomfort society feels in witnessing the impact of the reality of death and the pain of grief (Vachon & Rogers, 1984).

The involvement of nurses with both the dying and surviving members of a family provides a strong argument for increased understanding of the bereavement process and the risks associated with coping with death. As health care professionals we need to ask what is helpful to the widowed. The identification of early signs of health problems, educating the widowed to existing resources that are available, making needed referrals and acting as a professional and social contact might be very helpful to the widowed person. In other words, nurses need to know what serves to maintain the physical, psychological, and social health of the widow after the death of the spouse.

The extent to which the Newfoundland culture and environment would impact on the response to bereavement has not been identified and yet has a major part to play in identifying those factors that might be helpful to the Newfoundland widow. Traditionally, factors such as the historical development, the physical environment, the family-oriented social relationships and the impact of religion have influenced the people in Newfoundland in having close ties with their families, friends and communities. This would certainly lead one to question whether widows in Newfoundland respond to the loss of a spouse differently than those in other cultures or environments.

Research Questions

Major research questions which were addressed were:

1. What are the characteristics of middle-aged Newfoundland widows?

2. Is the level of psychological distress directly related to the widow's perception of social support that occurs during the first year of bereavement?

Purposes of the Investigation

The purposes of this investigation were to describe a sample of middle-aged Newfoundland widows and to determine the nature of a relationship between psychological distress and social support during the first year of bereavement. Identification of this information may help nurses who are working with these clients to identify factors which might contribute to problems in adjusting to new roles following the death of a spouse.

CHAPTER II

LITERATURE REVIEW

Research has shown that social support is an important intervening variable between a major life event and a positive outcome. One should expect to find then that the health consequences of bereavement might be moderated by the availability of alternative sources of social support. In order to work towards the development of a conceptual framework for this investigation, the literature is presented in the following order: bereavement, conjugal bereavement, social support, social support in bereavement and characteristics of widows that influence bereavement outcome and/or social support in bereavement.

Bereavement

The terms 'bereavement' and 'grief' are usually used synonymously. However, there is a distinction. Bereavement is the objective situation of an individual having lost a significant person by death (Parkes, 1972); grief is the bodily, emotional and psychological changes that the bereaved individual usually, but not always, experiences. Although most individuals who are bereaved manifest grief, there are exceptions. As Lindemann (1945) observed, some bereaved individuals have delayed grief or never grieve at all.

Acute grief is often regarded as 'typical' or 'normal' when characterized by initial shock, disbelief and denial

followed by anguish and extreme sadness. Numerous authors suggest that these signs and symptoms of acute grief last for several weeks or months, ending with recovery. While some inconsistencies appear in these stages, the manifestations of grief following the death of a significant other are nonetheless generally agreed upon (Murphy, 1983).

Three phases in the normal grieving process have been identified (Clayton et al., 1968; Glick et al., 1974; Maddison & Viola, 1968). The initial phase, beginning at the time of the death and usually lasting until several weeks after the burial of the deceased, is characterized by feelings of numbness, emptiness, disbelief and profound sorrow. The intermediate phase of normal grief begins several weeks after the funeral and ends approximately one year later. This phase is characterized by obsessional review of the death, searching for the meaning of the death and in some cases, searching for the deceased. The recovery phase, usually beginning in the second year of bereavement, is characterized by behaviours directed at reorganizing life goals and more aggressive social life.

According to Parkes (1965) the "typical reaction to bereavement" begins with a period of numbness, followed by wave-like attacks of yearning and distress with autonomic disturbance, which are aggravated by reminders of the deceased. Between attacks, the bereaved person is depressed and apathetic, with a sense of futility. Associated symptoms

are insomnia, anorexia, restlessness, irritability with occasional outbursts of anger directed against others or the self, and preoccupation with thoughts of the deceased. The dead person is commonly felt to be present, and there is a tendency to think of him as if he were still alive and to idealize his memory. The intensity of such feelings begins to decline after one to six weeks and is minimal after six months, although for several years occasional brief periods of yearning and depression may be precipitated by reminders of the loss.

Conjugal Bereavement

The death of a marital partner, particularly within Western culture, has strong psychological and social consequences for the survivor. According to Maddison (1968):

> A widow is faced with two concurrent tasks: she is required, through the processes of mourning, to detach herself sufficiently from the loss object to permit the continuation of other relationships and the development of new ones; at the same time, she has to establish for herself a new role conception as an adult woman without a partner. (p. 223)

There have been numerous studies of conjugal bereavement. Rather than present them all in detail, emphasis is placed here on the relatively recent work of the major groups of investigators who conducted large studies that focused on variables relevant to the present research, especially the variable social support.

The first set of modern studies was conducted in the mid-sixties by investigators at Harvard University using samples from the United States and Australia. Maddison & Viola (1968) and Maddison & Walker (1967) studied a non-random sample of 132 American and 221 Australian widows (age of the deceased ranged from 45-60 years) to identify those widows most likely to suffer physical and/or psychological problems following conjugal bereavement and to determine whether a widow's perception of environmental support would be correlated with eventual outcomes. The study was designed to retrospectively examine the widow's interaction with the environment as perceived by the widow 13 months post-bereavement. Bereavement crisis was defined as up to 3 months after the husband's death. Data were collected by a mailed questionnaire which consisted of 57 items that measured the widow's health in bereavement. The response rate was 50%. Phase two involved an indepth interview with 20 women who were judged to have 'good outcomes' and 20 women who were judged to have 'bad outcomes' on the basis of the responses to the questionnaire. The composite findings were: 1) the younger the widow, the more likely she was to experience higher illness scores; 2) more than one widow in three had increased her consumption of drugs, usually sedatives and tranquilizers; one in nine widows reported a marked increase in smoking; 3) 'bad outcome' widows perceived more unmet needs in their interpersonal exchange during the 3 month bereavement period than 'good

outcome' widows; 4) 'bad outcome' widows found the environment unhelpful during the crisis period. The most serious criticism of these studies is the use of cross-sectional design with recall of health-illness symptoms over the past year being captured during the one time period of data collection.

The second group of studies was conducted in St. Louis. Clayton et al. (1968) studied a random sample (n = 109) of widows and widowers for the following purposes: 1) to define a group of bereaved persons with a constellation of depressive symptoms and compare them on a number of demographic, physical and social variables to bereaved people without these symptoms, and 2) to compare bereaved subjects with depression to non-bereaved hospitalized subjects with clinical diagnosis of depression (Bornstein et al., 1973; Clayton, 1975; Clayton et al. 1968, 1972, 1973). The study was designed prospectively with the sample selected from newspaper obituaries. The response rate was 58%. The average age of the sample was 62 years; the range of ages was 20-90 years. Structured and semi-structured interviews were conducted 1, 4, and 13 months after bereavement. Depression was defined as a subjective report of low mood, plus at least five of the following eight symptoms: decreased appetite and/or weight loss, sleep problems, fatigue, restlessness, loss of interest, difficulty in concentrating, guilt or thoughts of suicide. Findings from this study were: 1) depression at 1 month was a major predictor of depression at

1 year; 2) bereavement itself, rather than the effects of loneliness or social isolation, influenced the occurrence of depressive symptoms as well as the seeking of medical attention for symptoms 1 month after the loss of the spouse; 3) anticipatory grief did not make mourning either less intense or shorter. In this study, the concept of anticipatory grief was not appropriately operationalized. Anticipatory grief was defined simply as the length of the illness of the deceased. The critical issue in anticipatory grief is the extent to which the spouse and ill person use the time to bring closure to their relationship and use the opportunity for final sharing. This dimension of anticipatory grief was not addressed.

A third research group, also from Harvard University, produced a number of studies with important findings about subjective assessment of general health, presence of somatic and psychological symptoms, extent of medical consultations post-bereavement, admission to mental institutions, mortality among widows, unexpected and untimely bereavement, availability and use of help, and changing relationships with family and friends (Parkes, 1964, 1965; Parkes et al., 1969, 1972; Parkes & Brown, 1972; Glick et al., 1974; Parkes, 1975). The study of Glick et al. (1974) of young widows will be reviewed here as the findings are pertinent to this investigation.

Glick et al. (1974) documented the process and outcomes of the first year of bereavement in a prospective study of bereaved persons and matched controls of a random sample of

49 widows and 19 widowers from Boston and Cambridge who were under the age of 45 years and whose names were obtained from death notification forms. The response rate was 56% for widowers and 60% for widows. The control group of married men and women was closely matched for age, sex, size of family, nationality and social class. Data were collected by loosely structured tape recorded indepth interviews at 3 and 8 weeks and 13 months. Findings on data with high inter-coder reliability for widows were: 1) the early emotional and physical responses included shock, sadness, crying, confusion, loss of appetite, body aches and pains, lethargy, fear of losing control and anger at doctors, at deceased, at self; 2) the period of deep and continued grief seemed to last only a few weeks, or at most a few months and failure to begin to move toward recovery during the first year seemed to signal continued difficulty thereafter; 3) loneliness was the one symptom that did not seem to fade with time; 4) the course of recovery was marked by periods of moving forward as well as periods of relapse into grief and despair; 5) changes in relationships with family and friends occurred for all widows, most widows felt closer to their children, parents and siblings and many widows reported conflicting relationships with inlaws after the immediate period of grief; and 6) by the end of the first year of bereavement most widows had established a new friendship network from that which they had maintained during their marriage and many sought the friendship of other widowed persons

or single women. The work by this group (Glick et al., 1974) is commendable. Measures were carefully defined; the design was longitudinal with the first contact early in the bereavement process; a matched non-bereaved control group was used; data were collected by personal interview and subjects had the opportunity to report their experiences in an unstructured way.

The fourth study reviewed here was part of a longitudinal study of the physical, psychological and social reactions of middle-aged widows in Canada (Sheldon et al., 1981; Vachon et al., 1980, 1982). The authors interviewed 162 widows married to men aged 67 and under who died in seven Toronto hospitals during a 17 month period. The 162 widows who agreed to participate represented 88% of available subjects who were suitable for participation. The average age of the widows was 52 years. Data were acquired by means of an author constructed questionnaire and a structured interview at 1, 6, 12 and 24 months during bereavement to determine which sociodemographic, prebereavement variables and circumstances of the husband's death were related to psychological distress level. Case studies were used to add clinical observations to the quantitative data being reported. High distress was operationalized as a score of 5 or more on the 30 item Goldberg General Health Questionnaire (GHQ) while low distress was operationalized as a GHQ score of 0-4. Findings from this study were: 1) the most important variable associated with high distress at 1 month was the woman's perception that

she was seeing old friends less than before her husband's death; 2) at 2 years, it was possible to predict high or low distress levels with 86% accuracy by means of a multiple regression analysis using 10 variables, the most significant of which were 1 month GHQ score, short final illness of the husband, and satisfaction with available help; 3) it was found that a lack of social support in the initial crisis period was predictive of high distress two years after the death of the husband; 4) 26 of 99 women remained highly distressed throughout the course of the study but 30 women never gave evidence of 'high' distress; and, 5) deficits in social support, health and financial problems correlated with enduring 'high distress'.

The review of literature about Newfoundland uncovered only one study (Robertson, 1979) of a bereaved population. Sixty widows in 10 outport communities were interviewed with a questionnaire by members of the Newfoundland Women's Institutes to document the difficulties and problems experienced by rural widows as well as sources of financial and social help which they found. As a result of this study a handbook for widows was published.

In summary, the studies of bereavement indicated that: social support systems were found to have a crucial part to play at all stages in adaptation to bereavement (Maddison & Walker, 1967; Vachon et al., 1982); individuals in the early stages of bereavement experienced considerable psychological

distress (Clayton, 1973; Parkes & Brown, 1972); early psychological distress was found to be a major mental health risk factor for the bereaved (Clayton et al., 1972); separately and in combination, variables such as low socio-economic status, husband's sudden death, multiple life crisis and reactions of psychological distress, yearning, anger and self-reproach at 1 month were found to be predictors of poor outcome at 13 months (Parkes, 1975; Vachon et al., 1982). Only one study was found that considered the combined factors of social support, psychological distress and physical responses to bereavement in a middle-aged population (Vachon et al., 1982). Most studies dealt with large urban populations (e.g. London, Boston, St. Louis, Sidney, Toronto). The one study in Newfoundland was not designed to assess the prevalence of psychological, social and physical problems in response to a loss of a spouse, rather it documented types of problems and resources that might be useful in their amelioration.

Social Support

The concept of social support has not yet acquired a consensual definition (DiMatteo & Hays, 1981) and is viewed as a complex concept requiring multiple measures of its many dimensions. Social support, as pointed out by House (1984), is a concept that at a minimum involves:

> a flow of one or more of four things between people: 1) emotional concern (empathy, caring, concern); 2) instrumental aid (giving money, assistance); 3) information (advice, suggestions, directions); and/or 4) appraisal or social comparison relevant to a person's self-evaluation (p. 93).

Table 1 presents major conceptualizations of social support.

Social support can be interpreted as coming from a variety of sources: spouse, family, friends, neighbours, supervisors and co-workers, and health care professionals. Because of that, it cannot be defined only in terms of one's relationship to one other person (e.g. spouse). Researchers are taking greater care in delineating the particular source(s) of support and the nature of support emanating from each.

An important distinction to be made when discussing social support is between the number of relationships a person has and the person's perception of the supportive value of those interactions. The former is usually referred to as the social network; the latter as perceived social support. The benefits of social relationships are assumed, not measured, in the social network concept while in the concept of perceived social support, effort is made to assess the recipient's evaluation of the supportive quality of a relationship, either in general or in specific contexts (Schaefer, Coyne & Lazarus, 1981).

TABLE 1

Major Conceptualizations of Social Support

Study	Conceptualization
Weiss (1974)	proposed six categories of social relationships that are provided from a number of sources with differing degrees of specialization and overlap: 1) the provision of attachment refers to gaining a sense of security and place; 2) social integration is provided through a network of relationships in which participants share concerns, information and ideas; 3) opportunity for nurturance refers to an adult taking responsibility for the well-being of a child; 4) reassurance of worth occurs through recognition of an individual's competence in a social role, such as work or child rearing; 5) a sense of reliable alliance is provided primarily through relationships with kin in which the individual is assured of continuing assistance; and 6) the obtaining of guidance occurs during stressful situations when the individual seeks emotional support and cognitive guidance from a trustworthy and authoritative figure.
Caplan (1974)	characterized social support to include the notion that support is of a continuing nature through enduring relationships which provide help for the individual in mobilizing psychological resources and mastering emotional burdens, sharing tasks and providing material supplies, skills and cognitive guidance. The social support system functions by offering information, guidance and feedback to the individual and by acting as a refuge or sanctuary where the individual may experience stability and comfort.

Study	Conceptualization
Cobb (1976)	defined social support as information leading the person to believe that he or she is cared for and loved, esteemed and valued and part of a network of communication and mutual obligation. Unlike Caplan (1976), Cobb does not consider tangible services or material aid to be a form of social support.
Kahn & Antonucci (1980)	defined social support as interpersonal transactions that include one or more of the following key elements: affect, affirmation and aid. Affect refers to an expression of liking, admiration, respect or love. Affirmation is characterized by an expression of agreement or acknowledgement of the appropriateness or rightness of some act or statement of another person. Aid includes those transactions in which direct aid or assistance is given including things, money, information, time and entitlements.

The potential of the network as an approach to the study of social support has been noted by many authors (Murawsk et al., 1978) and in spite of its limitations, it still continues to be used. Social network theory provides a useful framework for integrating the various mechanisms and interplay of variables that constitute the opportunity of social support (Maxwell, 1982). Social network theory can also be used to describe not only an individual's immediate family but also all those with whom he/she has regular contact.

Social network refers to a "specific set of linkages along a defined set of persons" (Mitchell, 1969). Social network is a social construct; it defines the actual number or quantity of interpersonal relationships (e.g. number of family members, friends, or club memberships). A network can be described in terms of its composition and structure (e.g., the number of people involved and the number who know each other) or by the nature of particular relationships (e.g., friendship vs kinship). Following Mitchell, Kaplan et al. (1977) suggested a number of properties of social networks that might be relevant to health, such as content of the support, directness, intensity and frequency.

When structural measures of social network size are used to indicate the benefits of social relationships, two questionable assumptions are made: that any benefits are directly proportional to the size and range of the network and that having a relationship is equivalent to getting

support. While it is likely that social network size and amount of social support are positively associated, this assumption ignores the demands, constraints and conflicts also associated with social relationships (Schaefer, Coyne & Lazarus, 1981).

There have been a few investigations into the relationship between social networks and health outcomes. All studies utilized self-reported measures. One study of social networks and health outcomes was Berkman and Syme's study (1979). The authors measured social network with an index based on marital status, numbers of close friends and relatives and membership in community organizations. The social network index predicted all-cause mortality rates in a random sample of 6928 adults in Alameda County, California followed for 9.5 years. The findings were: 1) people who lacked social and community ties were more likely to die during the years of study than those with more extensive contacts; and, 2) the age-adjusted relative risks for those most isolated when compared to those with the most social contacts were 2.3 for men and 2.8 for women.

Social support is distinguished in the literature from the more structural concept of network by its focus on the nature of the interactions taking place within social relationships as those are evaluated by the person. Social support is a psychological construct: the perceptions of an individual regarding the quality of his or her inter-personal

relationships. In other words, the extent to which social support is attributed to a situation or a relationship involves an appraisal by the recipient of whether and to what scope an interaction, pattern of interactions, or relationship is perceived as helpful.

Three recent studies utilizing self-reported measures illustrated this approach. Using a suburban Australian sample (n = 863), Andrews et al. (1978) studied the effects of life event stress, coping style and social support on psychological impairment. Psychological impairment was defined as a score of 4 or more on the 20 item General Health Questionnaire. The authors found that expectations of help in a crisis from friends, relatives or neighbours were negatively correlated with psychological impairment but network based measures of neighbourhood interaction and community participation were not correlated. Gore (1978) studied the effect of social support in moderating the health consequences of unemployment. The investigator used a 13 item index to assess subjects' perceptions of the support given by wives, friends and relatives and examined the relationship of perceived support to the health of 100 men who lost their jobs because of factory closings. This longitudinal investigation involved five interviews over a two year period. Findings of this study were that: 1) men who were not immediately re-employed and who felt unsupported had higher serum cholesterol levels and more symptoms of

illness; and, 2) unsupported men also experienced more depression regardless of employment status.

In summary, previous research indicates that it is necessary to distinguish between perceived social support and social networks as they had different effects on health, morale and psychological functioning. Social support was more strongly associated with health outcomes because it was a more direct measure of the support afforded a person, presuming that it was indeed the operationalization of social support rather than some other aspect of social relationships which was important to outcomes (Andrews et al., 1978). Social network measures encompassed many psychological processes within the same measure, not all of which had positive consequences for adaptation (Berkman & Syme, 1979). Positive consequences included being embedded in a network of persons who could provide diverse types of support when needed in specific stressful encounters or who provided meaning to one's life in general (Andrews et al., 1978). Negative processes might include the stressful demands made by others, the constraints they exercise over one's choices, the efforts required to sustain the network, and the disappointments often inherent in such relationships when help is needed but not provided (Schaefer, Coyne & Lazarus, 1981).

Social Support in Bereavement

In the past twenty years, there have been a number of studies which highlight the central importance of social support in the lives of women after the death of a spouse. Emphasis is placed here on the work of the major groups of investigators who have conducted studies relevant to the present research.

Maddison and Walker (1967) studied 132 widows from Boston and 221 from Sydney, Australia and compared them with matched controls of married women. This investigation focused on the widow's perception of the degree of supportiveness of her social network during the first three months of bereavement. Findings related to social support were: 1) widows with a positive outcome reported an appreciation of permissive support from others and encouragement by others to express their feelings was unnecessary; and, 2) widows with a negative bereavement outcome reported a high frequency of perceived unhelpful interactions during which they thought that people in their support networks failed to meet their needs; covertly or overtly opposed the expression of their feelings and were attempting to focus their attention to the present and future and away from the past.

The second study described older widows (n = 1,169), fifty years of age and over, who lived in metropolitan Chicago (Lopata, 1970, 1973, 1978, 1979). The women had been bereaved an average of ten years, after a marriage of thirty

years or more. Data were collected by interviews which dealt with how well widows were managing their lives and the support systems they developed from the resources available to them. The widows' support systems were defined as a set of actions or objects which the giver or receiver or both defined as necessary or helpful in maintaining a style of life. Lopata concluded that women with more income and education are hit hardest by widowhood, but also have more resources to build a satisfying new life. She also found that a sizable number of widows were relatively isolated. This was related to a series of factors: 1) the more dependent a wife is upon her husband for various social roles, the more disorganized the social relationships they shared become upon his death; 2) social relationships developed in earlier years and women are not trained to enter new relationships voluntarily; 3) previous friendships centering around the marital dyad are not continued after the death of the spouse; and, 4) when a husband dies, there is no prescribed replacement for him. Lopata found that widows' involvement within the neighbourhood and voluntary agencies was negligible or superficial. Additional findings were: 1) children and, in the case of younger widows parents, were found to be quite frequent contributors to the support system of the widow; 2) contact with children away from home tended to be relatively frequent, slightly less than once a week, and 3) siblings were essentially absent

from the emotional support system of widowed women and were not generally sources of psychological closeness.

The third study reported characteristics of 233 widows, of varying ages involved in a widow to widow program in Dorchester, Massachusetts (Strugnell, 1974). Several pertinent observations were made in relation to work and support networks: 1) women who work during the bereavement period seem more independent and self-assured, perhaps because work offers an opportunity for an identity separate from widowhood and for various interpersonal relationships; 2) some widows keep so busy with work that they delay dealing with their grief reaction; 3) the most helpful network in the first months of bereavement is the widow's family, especially grown children and grandchildren; 4) the role of grandmother particularly was related to a more satisfactory adaptation to widowhood; and, 5) family and former friends seem to lose interest after several months and widows perceive a need for contacts and relationships which family and former friends do not fulfill.

The fourth study was a longitudinal study (previously introduced in the review of the literature on conjugal bereavement) of 162 widows who had been married to men who were aged 67 and under in Toronto, Canada (Vachon et al., 1982). In this study the social support variables were the most important in explaining the level of distress 1 month after bereavement. In this research, a "Perceived Lack of

Social Support Index" was developed, and included such items as: the feeling that no one cares; finding it hard to carry on social activities alone; seeing old friends less; receiving less help than wanted from family and friends; and being able to count on not more than one person to understand how one is really feeling. This perceived lack of social support accounted for fully 25% of the variance in distress levels one month after bereavement. In follow-up interviews it accounted for 12% and 13% of variance in psychological distress at six and twelve months respectively, and only at 24 months did it decrease to 5% (Vachon, 1981).

Other findings indicated that: 1) in comparison to younger widows (aged 45 or less) older widows were more likely to be living alone, less likely to have children and more likely to have children living outside Toronto; 2) older widows were more likely than younger to rate themselves as having received help from children over 18, from other widows and from clergy; 3) the most frequent sources of social support to all widows were their children, members of their family of origin (e.g. parents, siblings) and friends; 4) 73% of the widows experienced at least one change in their relationships with others over the first two years of adaptation to bereavement; 5) there was a statistically significant association between the number of relationship changes a woman experienced and her score on the Goldberg General Health Questionnaire (a measure of psychological distress);

6) there was a statistically significant association between the development of relationships and bereavement outcome (76% of the low distress women had developed new relationships two years after bereavement compared to 57% of the high distress women); 7) friendships were the crucial relationships most likely to change during bereavement (six months after bereavement half of the women noted a decrease in social relationships); 8) a primary focus of the support of adult children involved getting their mothers into new activities and encouraging their mothers to maintain old contacts as sources potentially of remarriage or employment; and 9) given a deterioration in her health, a widow may experience high distress even in the presence of social support.

The fifth study, a pilot project, was conducted in Canada in 1981 and focused on the later period of widowhood (Martin Matthews, 1982). The pilot project was designed to determine the suitability for a parallel Canadian study using the Lopata research design and instrument. Martin Matthews interviewed 26 widows in the Guelph area, identified through obituary notices appearing in local newspapers between 1972 and 1977. The women ranged in age from 46-86 and were widowed an average of 8.6 years after having been married an average of 34.3 years. Martin Matthews found stability over time in the contact with adult children, but also found substantial evidence for the support of members of the 'family of origin'. Further findings were that: 1) siblings and other extended

kin emerged as important figures in the social and emotional support systems; 2) 54% of the widows listed at least one sibling (typically a sister) as being involved in at least one exchange in the social support system; 3) 65% listed an extended kin member (siblings, sibling-in-law, cousin, aunt or niece) as involved in their emotional support system; 4) half of the respondents specifically referred to a sister as one of the three people to whom they felt closest, either currently or in the year before their husband's death; and 5) over half of the respondents saw at least one sibling as frequently as several times a month.

In summary, the comparison of findings of Canadian studies with those of American studies demonstrated striking parallels as well as interesting contrasts. The importance of female relatives, particularly daughters, in the social support systems of widows was striking in both the Canadian and American research. However, the role of the extended family in the support system of the widow was found to be apparently quite different in Canada. While Lopata (1973) found almost a complete absence of meaningful support from family members other than children, the Canadian studies identified other members of the extended family as involved in the social support systems of the widowed. While none of the Canadian studies were individually of the scope and comprehensiveness of Lopata's research, collectively they did point to a notable consistency in the identification of

the supportive role played by extended family members in all stages of widowhood (Martin Matthews, 1985). This was most evident in reference to the role of peer family, especially siblings, a finding made more significant by its contrast to Lopata's statement that:

> ...one of the most unexpected findings of this study ...is the absence of siblings from the emotional support systems of widows (1979, p. 242).

Characteristics of Widows that Influence Bereavement Outcome and/or Social Support in Bereavement

The individual's perception of a stressful event is important in evaluating the impact of that event (Rabkin & Struening, 1976). Such perceptions depend upon the individual's thoughts, feelings, behaviour patterns, interpersonal relationships, intelligence, coping abilities, past experiences, physical and hereditary characteristics and a sense of mastery (Hauser, 1983). Demographic characteristics such as age, education, income and occupation also are pertinent (Rabkin & Struening, 1976). These individual factors influence the appraisal of the event as threatening, neutral or challenging, and the nature of the coping abilities employed. Some of these factors have been related to bereavement outcome.

For example, throughout the widowhood literature, accounts of the devastating effects of financial insecurity on bereaved

women abound (Caine, 1974; Love, 1974; Wylie, 1977). Worries about basic economic survival were so pervasive in widowhood that some researchers found them to be the cause of longterm lack of affiliation and low morale among the widowed. Harvey and Bahr (1974) conclude that:

> The widowed have appeared to have more negative attitudes than the married because they are much poorer than the married, and they have appeared less affiliated for the same reason. (p. 99)

The type of death and the way in which it was perceived had an effect on health. Vachon et al. (1976) found widows of cancer patients were suffering more in their health one or two months after the death than widows of men who died for other reasons.

Regarding the physical and psychological characteristics, some studies reported a higher incidence of somatic complaints (physical illnesses) and even death among bereaved persons in general (Parkes, 1964, 1972; Parkes, Benjamin & Fitzgerald, 1969; Rees & Lutkins, 1967; Young, Benjamin & Wallis, 1963). The first year of bereavement was generally thought to be the period when the widow was most vulnerable to deterioration in health (Ball, 1977; Clayton, Halikes & Maurice, 1971; Maddison & Walker, 1967; Parkes, 1970) but some evidence indicated continuing or even greater deterioration in health after the first year (Bunch, 1972; Cox & Ford, 1964; Vachon, 1979).

Socially, many widows had a strong desire to be independent and tended not to live with their offspring, preferring intimacy at a distance (Chappell, 1986). Arling (1976) found that widows who were the least lonely and felt the most useful were those who have a number of neighbours and friends. He reported that it was the availability and not the amount of contact that was significantly related to morale, suggesting the importance of feeling that there are caring individuals around. MacElveen (1978) noted that sources of help preferred by many individuals in times of stress were primary groups (religious, neighbours and friends) rather than professionals, agencies or institutions.

Summary

The review of the literature revealed:

1. Individuals in the early stages of bereavement experience considerable psychological distress (Clayton, 1973; Parkes & Brown, 1972).

2. At 2 years, it was possible to predict psychological distress levels by means of multiple regression analysis using 10 variables, the most significant of which were one month GHQ score which measures psychological distress, short final illness of the husband and satisfaction with available help (Vachon et al., 1982).

3. Lack of social support in the initial crisis period was predictive of high distress two years after the death of the husband (Vachon et al., 1982).

4. It is necessary to distinguish between perceived social support and social networks as they have different effects on health, morale and psychological functioning (Schaefer, Coyne & Lazarus, 1981).

5. Perceived social support was more strongly associated with health outcomes because it was a more direct measure of the support afforded a person (Andrews et al., 1978).

6. Expectations of help in a crisis from friends, relatives or neighbours were negatively correlated with psychological impairment but network based measures of neighbourhood interaction and community participation were not (Andrews, et al., 1978).

7. It seems probable that the change in the level of psychological distress might be affected by the change in the level of social support during the first year of bereavement (Vachon et al., 1982).

8. Widows in Canada responded similarly but differently than widows in the United States to the loss of a spouse in that they identified additional members of the extended family other than children in their support systems (Martin Matthews, 1982).

9. The individual characteristics of the widow such as income, type of death, morbidity, number of neighbours and friends, sources of help were important in evaluating the impact of a stressful event and have been related to bereavement outcome (Rabkin & Struening, 1976).

10. No study in Newfoundland has considered the combined factors of social support, psychological distress and physical responses to bereavement in a middle-aged population.

Conceptual Framework

The conceptual model for the study is an adaptation of Kahn & Antonucci's model of social support (Kahn & Antonucci, 1980). The Kahn & Antonucci model was chosen as it was the basis for the Norbeck Social Support Questionnaire which was designed to measure multiple dimensions of social support. It also allowed the investigator to explore separately the two components of social support (social support network and functional social support) in order to provide a more comprehensive view of social support during the first year of bereavement.

Kahn & Antonucci (1980) defined social support as interpersonal transactions that include one or more of the following key elements: affect, affirmation and aid. Affect refers to an expression of liking, admiration, respect or love. Affirmation is characterized by an expression of agreement or acknowledgement of the appropriateness or rightness of some act or statement of another person. Aid includes those transactions in which direct aid or assistance is given including things, money, information, time and entitlements.

The concept of convoy is central to Kahn & Antonucci's theory. Convoy refers to a set of significant persons to whom one is related by giving or receiving social support (Kahn & Antonucci, 1980, p. 269). Thus, the convoy consists of two subsets, those on whom one relies for support and

those who rely on one for support. Kahn & Antonucci suggested that these two subsets may overlap as, for example, in instances where the relationship is symmetrical. However, reciprocity is not necessarily inherent in the conceptualization of social support (Kahn & Antonucci, 1980).

The term 'social network' is often used inter-changeable with 'convoy'. One's social network is not static as changes in network size occur over time. As well, each network member holds a varying degree of importance to the focal person (Kahn & Antonucci, 1980).

In their model of social support, Kahn & Antonucci (1980) suggested that personal properties (for example, age, abilities) and properties of a particular situation (e.g., opportunities, resources) influence the requirements for social support, the convoy structure (e.g. size, connectedness), the adequacy of the social support received, and the outcomes: individual performance and well-being. They indicated that the influence of both sets of properties on individual well-being is moderated by the convoy structure and the adequacy of social support received (Kahn & Antonucci, 1980). Kahn & Antonucci's model of social support (1980, p. 270) is depicted in Figure 1.

Kahn & Antonucci (1980) considered the "life course perspective" to be influential in determining the amount and form of social support appropriate at a given time. Specifically, both an individual's past experiences and the changes in

his/her needs for social support as he/she moves through the life cycle are important determinants of the requirements for social support. When any of a person's life role undergoes change, Kahn & Antonucci considered that the need for social support is heightened.

The conceptual model for the investigation is depicted in Figure 2. Kahn & Antonucci's model suggests that social support is a buffer between a stressful event and an individual's well-being. In the investigator's conceptual model, a particular situation (death of a spouse) is the stressful event and the outcome is the widow's performance and well-being, the level of psychological distress experienced during the first year of bereavement.

Three modifications were made to Kahn & Antonucci's model. First was the identification of three main characteristics of the widow: 1) background and personal characteristics, 2) physical and psychological health characteristics and 3) social characteristics. These were highlighted as they influence the requirements for social support, the convoy structure and the adequacy of the social support which affects the widow's outcome.

A second modification was to relabel the convoy structure as perceived social support network and the adequacy of social support as the perceived functional social support in order to identify separately the two components of social support influencing the widow's outcome. The perceptions of

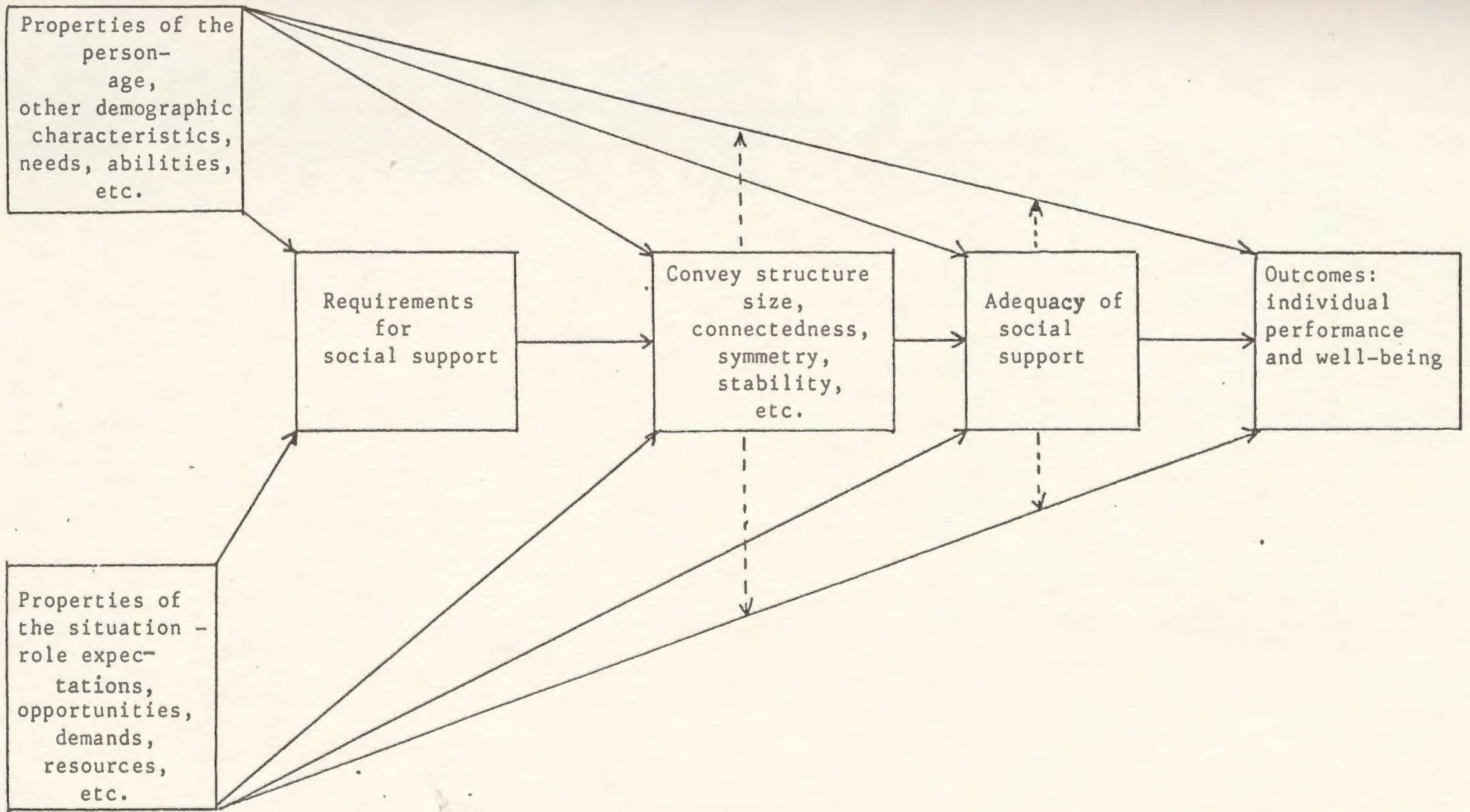

Figure 1: Kahn and Antonucci's model of social support (1980)

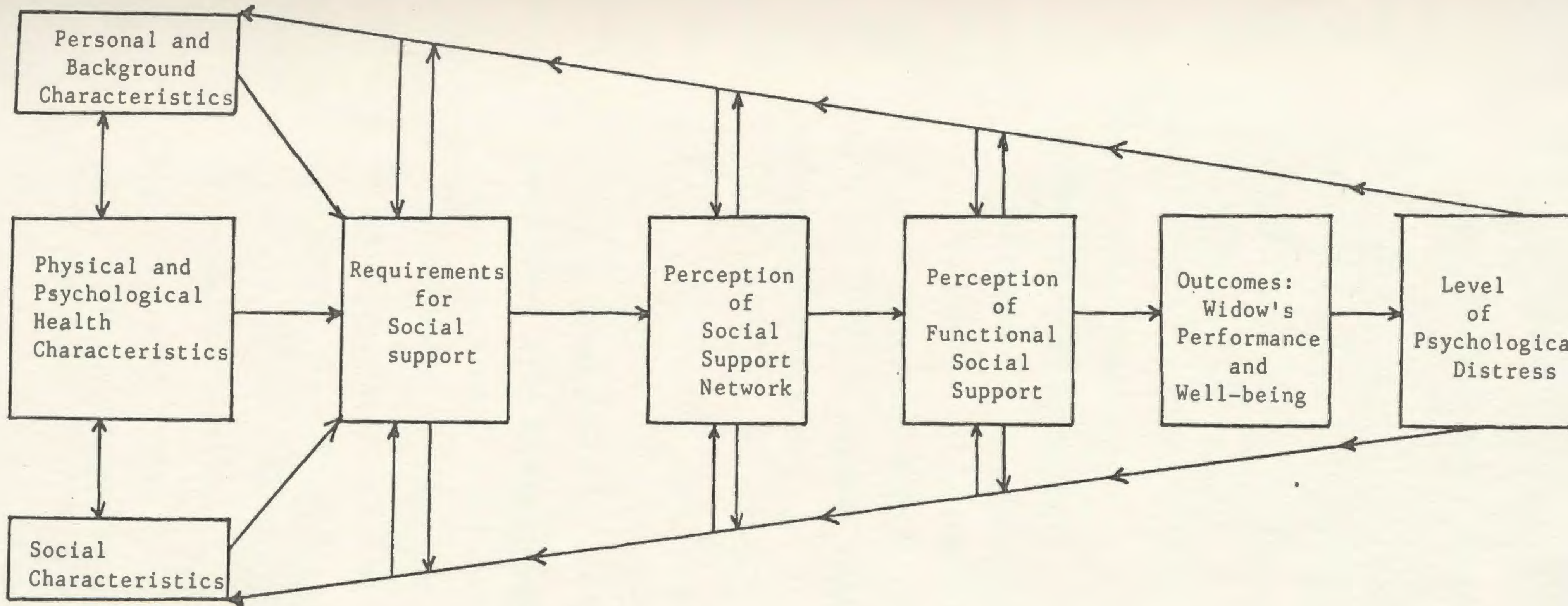

Figure 2: A model to determine widow outcome as influenced by personal and background characteristics, physical and psychological health characteristics, social characteristics, perceived social support network and perceived functional social support. (Adapted from Kahn and Antonucci, 1980)

the two components were being identified as they more accurately than the Kahn & Antonucci model measured the widow's evaluation of her social network and the quality of her functional social support. It must be acknowledged that not everyone seeks or needs equal amounts of social support in times of life stress such as bereavement.

As a result, a third modification was to provide feedback loops so that the outcome itself may influence the three main characteristics of the widow, the requirements for support, the perceived social support network and the perceived functional social support. These feedback loops provide for re-activation of the perceived social support network and perceived functional social support if deemed necessary to improve or sustain the outcome, the level of psychological distress. This is a continuous process during the first year of bereavement.

The three main characteristics of the widow define the requirements for social support. Demographic variables such as age, religion, culture, education and income influence how much social support may be needed by the widow, as well as how much might be available to her. Similarly, individual differences in needs, abilities and orientations are likely to influence need for, availability and use of social support. The qualitative aspects of this study will shed more light on the extent to which these variables influence social support. Kahn & Antonucci did not define requirements for

social support in their model. The investigator recognizes that these requirements will influence the perception of social support network and the perception of functional social support given by the network as they are specific to the individual widow.

As in the Kahn & Antonucci model of social support, it is assumed that in the model for the present situation, if the widow perceives herself as having social support during this time of bereavement then she will gradually be able to make the transition to widowhood, assume a new identity, take on new activities and establish new relationships. Then, as she receives support in adapting to her husband's death and achieving new meaning in life, her level of distress will gradually decrease. However, if a woman perceives herself as having a lack of social support during this time of transition, she is much more likely to have difficulty in establishing her new identity, taking on new activities and developing new relationships. She may well continue to mourn for the past and for "what might have been" (Vachon, 1979).

Definitions and Usage of Terms in this Investigation

Bereavement - objective situation of an individual having lost a significant person by death (Parkes, 1972).

Widow - woman aged between 45 and 64 years at the time of the death of her husband and who has not remarried during the first year bereavement.

Background and personal characteristics - defined as those factors unique to each widow which affect the widow's cognitive appraisal of the event of bereavement and will ultimately effect the widow's outcome in bereavement. Operationalized as: age, place of birth, educational level, number of siblings alive, position of primary family, parent still living, religious preference, attendance at religious services, length of marriage, first marriage, children alive, children under 18, present work status, occupation, future work plans, perception of cause of husband's death, sudden versus chronic illness, discussed impending death with husband, living arrangements, experienced death before, income before death of husband, income after death of husband and driving status. The background and personal characteristics also include the characteristics of the widow's husband.

Physical and psychological health characteristics- defined as those factors unique to each widow which affect the widow's general health appraisal of the event of bereavement and will ultimately effect the widow's outcome in bereavement. These factors will compliment the responses on the standardized instruments which measured psychological distress. Operationalized as: widow's perception of her health since her husband died, professional help from physician or psychiatrist, professional help before husband died, taking tranquilizers or sleeping pills, feeling that there are things that are difficult to do now (e.g. concentrating,

making decisions, working outside the home, activities of daily living, meeting people, eating, sleeping, drinking, smoking and weight status).

Social characteristics - defined as those factors unique to each widow which affect the widow's cognitive appraisal of the event of bereavement and ultimately affect the widow's outcome in bereavement. These factors will compliment the responses on the standardized instrument which measured social support. Operationalized as: seeing and talking with close friends, husband's friends, family members and members of husband's family, how often these interactions are taking place, making any new friends - who, feeling closer to certain people - who, seeing some people less frequently - who, turn to anyone in particular to discuss problems - who, was there anyone especially helpful at the time of husband's death - who, anyone especially helpful since husband's death - who, and who took care of funeral arrangements.

Perceived social support network - described as "the convoy or vehicle through which social support is provided: An individual's convoy at any point in time thus consists of the set of persons on whom she or he relies for support and those who rely on him or her for support" (Kahn & Antonucci, 1980, p. 269; Norbeck, Lindsey & Carriere, 1981). Operationalized as: the Total Network subscale score on the Norbeck Social Support Questionnaire which is a self-report of number of persons

who provide personal support to the widow or who are important to her, duration of the relationships and the frequency of contact with network members.

Perceived functional social support - interpersonal transactions that include one or more of the following: the expression of positive affect of one person toward another; the affirmation or endorsement of another person's behaviours, perceptions or expressed views; the giving of symbolic or material aid to another ((Kahn & Antonucci, 1980; Norbeck, Lindsey & Carriere, 1981). Operationalized as: the Total Functional subscale score on the Norbeck Social Support Questionnaire which is an accumulation of scores of aid, affirmation and affect which an individual perceives as helpful.

Psychological distress - emotional symptoms of bereavement such as general nervousness, depression, fear of nervous breakdown, feelings of panic, persistent fears, repeated peculiar thoughts, nightmares, insomnia and trembling. Operationalized as a score of 5 or more on the 30 item General Health Questionnaire (Goldberg, 1972).

Interview I - semi-structured interview conducted by investigator with widow during the first three to six months of bereavement. Operationalized as: the administration of Widow Interview Guide I, Goldberg General Health Questionnaire and Norbeck Social Support Questionnaire.

Interview II - semi-structured interview conducted by investigator with widow during the second six months of bereavement. Operationalized as: the administration of Widow Interview Guide II, Goldberg General Health Questionnaire and Norbeck Social Support Questionnaire.

HYPOTHESES

The review of the literature and conceptual framework generated the following hypotheses:

a. Widows who have high levels of psychological distress during the first three to six months of bereavement will be more likely to have higher levels six months later than those whose initial distress is low. Statistically, score on psychological distress experienced by widows at the first three to six months of bereavement will be positively correlated with score on psychological distress six months later.

b. Widows with high scores on the perceived social support network scale during the first three to six months of bereavement will tend to have lower scores on this scale six months later, while those with low scores initially will tend to have high scores six months later. Statistically, score on perceived social support network at the first three to six months of bereavement will be negatively correlated with score on perceived social support network six months later.

c. Widows with high scores on perceived functional social support scale during the first three to six months of bereavement will tend to have lower scores on this scale six months later, while those with low scores initially will tend to have high scores six months later. Statistically, score on perceived functional social support at the first three to six months of bereavement will be negatively correlated with score on perceived functional social support six months.

d. The two components of social support (i.e. social support network and functional social support) perceived by widows at Interview I will be positively correlated with one another, as will the same two components of social support obtained at Interview II. Statistically, score on perceived social support network will be positively correlated with score on perceived functional social support both at the first three to six months of bereavement and six months later.

e. The level of psychological distress experienced by widows will vary with the level of social support they receive. The greater the social support the lower will be the psychological distress and conversely the higher the psychological distress the lower will be the social support. Statistically, 1) score on psychological distress experienced by widows will be negatively correlated with score on perceived social support network during the first three to six months of bereavement and during the second six months of bereavement, and
2) score on psychological distress experienced by widows will be negatively correlated with score on perceived functional social support during the first three to six months of bereavement and during the second six months of bereavement.

CHAPTER III

METHODS

Research Design

A descriptive correlational prospective investigation was conducted to describe a sample of middle-aged Newfoundland widows and to determine a relationship between psychological distress and social support during the first year of bereavement.

Setting

All interviews took place in the widow's home in the St. John's metropolitan area. Most of the interviews were conducted in privacy, away from family members, with only the widow and the investigator present.

The investigation was conducted at two time intervals during the first year of bereavement: 1) Widow Interview I was conducted within the first three to six months following the death of the husband, and 2) Widow Interview II was conducted six months following the initial interview. Data were collected over a nine month period.

Sample Selection

The sample of widows was obtained from the obituary column of the local evening newspaper. The target population consisted of female adults who had been married to men who were aged 45-67 years and residents of the St. John's metropolitan area. Since the number of females affected by

conjugal bereavement is greater than males, since almost one-third of the widowed population is between the ages of 45-64 and since this group is a relatively unstudied group, a sample of 45-64 year old widows was chosen. The death of the husband had occurred during a seven month period between September 1984 and March 1985. Transportation difficulties prevented the investigator from interviewing subjects outside the metropolitan area. Sixty-nine women met these initial criteria.

Of this population of 69 women, 17 women (25%) could not be contacted because addresses were not obtainable or phone numbers were not listed in the Newfoundland Telephone Directory.

The assessable population consisted of 52 women (75% of those who met the initial eligibility criteria). These women received a letter from the investigator approximately three to six months after the death of their husbands which explained the nature of the investigation (See Appendix A). Each potential subject was told that she would be contacted by telephone by the investigator who would provide further details of the study and, if the woman consented, an interview would be arranged to complete discussion of the details of the investigation, obtain consent and begin the interview. The letter stressed the confidentiality of information obtained and the freedom of each woman to refuse participation. Table 2 shows the outcome of initial effort to contact the total

TABLE 2

Outcome of Initial Effort to Contact Widows ($\underline{N}$ = 69)

Outcome	Number of Subjects	Percent
Agreed	34	49
Refused	8	12
Refused now but might be interested at another time	10	14
Unable to contact	17	25

population of 69 widows. No additional data was obtained from the obituary column in the newspaper on the women who could not be contacted.

From the accessible population, 35% refused. This refusal rate was within the range of other studies of widows where refusal rates ranged from 7-53% (Bornstein & Clayton, 1973; Glick et al., 1974; Maddison & Viola, 1968; Saunders, 1978; Silverman, 1971; Vachon, 1979). That 25% of the population were unable to be contacted was also comparable to other authors with reported rates ranging from 17-28% (Glick et al., 1974; Maddison & Viola, 1968; Parkes, 1972; Silverman, 1971; Vachon, 1979).

The sample consisted of the 30 women who agreed to participate and who met the following criteria in addition to the initial criteria:

1. The subject was between the ages of 45-64 and was not pregnant.
2. The subject's husband had died of 'natural causes' (i.e. illness as opposed to accident, suicide).
3. The subject had been married to the deceased for the previous five years.
4. The subject was available for an interview within the first three to six months following the death of the husband and for an interview six months later.

5. The subject spoke and understood English.
6. The subject was able to complete both interviews.

Each criterion for sample restriction was justified. Because of the sensitivity of the nature of the death event and the extraneous variables which would present themselves in pregnancy, pregnant women were excluded from the sample. 'Unnatural' death of husband (i.e. accident, suicide) might set up different responses in bereavement for the widow. A marriage of at least five years would signify an established relationship between the widow and her husband. The investigation was restricted to subjects who spoke and understood English, as the investigator was fluent only in this language. Completion of the interview was essential to the study design: there were women who were not available to complete Interview II because of a variety of reasons.

The mean age of the women was 54.9 years which, is comparable to the average age of widowhood in the United States (56) (Lopata, 1973) and in Canada (52) (Vachon, 1979). The women had been married an average of 31.5 years as compared to 34.3 years in Canada (Martin Matthews, 1982). Eighty percent were born in Newfoundland. Fifty percent had not finished high school as compared with 48% for St. John's and its metropolitan area (Statistics Canada, 1981).

The 10 women (14%) who refused at the initial contact but stated that they might be interested at another time responded with comments such as:

> Maybe later I would be interested. I am very busy with my mother who is ill and my family. I never have a chance to spend a moment alone.
>
> My son read your letter while I was away. He destroyed the letter thinking that I would not be interested. Perhaps later I would be interested.
>
> Don't feel up to talking about it now- call me back in a couple of months. I am still adjusting.
>
> I am not ready to talk with anyone now. My best friend's son who is 30 years old is dying with cancer and I cannot really think of talking with anyone about my husband at this time - maybe later.

Since the sample was obtained from the major newspaper of the city, it was necessary to examine factors which might have biased the source of the sample. The death notices from which the target population was obtained were published in the obituary column of the local evening newspaper during a seven month period between September 1984 and March 1985. Three major local funeral directors were contacted regarding what percentage of death notices printed in the obituary column of the newspaper actually reflected the number of deaths. The funeral directors reported that 98-99% of all deaths were published in the local newspaper. The local newspapers were researched for statistical information on

all male deaths recorded for the month of February 1985 to ascertain the percentage of all deaths of men 45-67 years who were listed as having a spouse. A description of information contained in obituaries for males in the St. John's metropolitan area for one month (February, 1985) is show in Table 4.

Attrition of Subjects

A problem common to all studies of bereavement is the high attrition rate due to refusals and to people lost to follow-up because of the high mobility of the newly bereaved (Vachon, 1979). With regard to subjects being lost to follow-up, the usual difficulties were experienced and it was impossible to re-contact some of the women because: two women moved out of the province and left no forwarding address, one woman had her telephone disconnected and one woman refused to participate in the second interview. The second interview was conducted with 30 women at 9-12 months.

The attrition group had a mean age of 61.0 years, had been married for an average of 37.7 years, all were born in Newfoundland and had not finished high school. Table 3 displays the means and standard deviations for psychological distress scores, perceived social support network scores and perceived functional social support scores for the sample and attrition groups during Interview I.

TABLE 3

<u>Mean Scores for Psychological Distress, Perceived Social Support Network and Perceived Functional Social Support and for Sample Group and Attrition Group During Interview I</u>

Group	n	Psychological Distress	Social Support	
		GHQ	Total Network subscale	Total Functional subscale
Sample	30	6	124	236
Attrition	4	8	115	305

TABLE 4

Information Contained in Obituaries for Males in the St. John's Metropolitan Area for One Month (February 1985; N = 54)

Category	n	Percent
Spouse mentioned	41	75.9
Ages of husband whose spouses were mentioned		
67 - 45 years	10	18.5
> 67 years	21	51.2
< 45 years	5	12.2
No age mentioned	5	12.2
Ages of men whose spouses were not mentioned		
67 - 45 years	4	30.7
> 67 years	3	23.1
< 45 years	4	30.7
No age mentioned	2	15.4

The Goldberg General Health (GHQ) score of the sample (6) was comparable with that of the attrition group (8). The attrition group scored lower on perceived social support network (Total Network subscale score 115) than the sample group (Total Network subscale score 124) and scored higher than the latter on perceived functional social support (Total Functional subscale score 305 vs. 236). These women seemed to have more psychological problems and yet had more functional social support than the women who stayed in the investigation. In addition, they all rated their health as worse since their husband's death. Three of the four women had gotten professional help from their physician. Therefore, it may well be that the sample for this investigation under-represents the problems of certain potentially high distress groups such as those with health problems and those with high psychological distress levels in early bereavement.

Protection of Human Subjects

Informed consent was obtained from subjects by following the policies for protection of human subjects of the Human Subjects Review Committee of the School of Nursing. All subjects were guaranteed confidentiality of data and were informed of the scope of their participation in the investigation, their rights regarding their participation in the investigation, and the risks and benefits of participating in the investigation. Letter of explanation and consent form

that were used to arrange and to obtain the subjects' informed consent are included in the appendices (Appendices A and B).

Procedure for Obtaining Informed Consent

When the investigator established that a subject met the initial criteria of the investigation, she approached the subject by letter to explain the nature of the investigation (Appendix A). This letter acknowledged the great stress of the bereavement process, emphasized the need for further investigation of the problem and introduced the research investigation. Within two weeks of the letter, a telephone call was made to the widow. When the subject agreed, a time (convenient with the subject) was arranged to set up the interview in the subject's home. When the subject agreed to participate in the study, written consent was obtained.

The investigator kept one consent form for her records and another consent was left with the widow (Appendix B). The interview was conducted immediately following the signing of the consent form.

Risks and Benefits

As far as was determined, this investigation presented no risks to the health or safety of the subjects. The investigator employed the following safeguards to minimize risk:

c

1. The interview was rescheduled if the subject felt unwell.
2. When questions were embarrassing to the subject she was allowed to abstain.
3. The investigator attempted to allay anxiety by providing a comfortable interpersonal environment and a relaxed, non-critical demeanour.
4. Problems identified during the interview which required intervention or referral were discussed with the subject following the interview, and appropriate referrals were made with the subject's consent.

There was no direct benefit to the subjects. The interview possessed a therapeutic value for some subjects by providing an additional opportunity to ventilate their thoughts and concerns regarding the bereavement. The major benefits of the investigation were related to improvement of future nursing care for both the widow and her family.

Preservation of Confidentiality

In order to ensure confidentiality, each subject was given a code number for the interviews. This list was available only to the researcher and was destroyed after data analysis was completed. Neither the subjects' names, nor any identifying characteristics appear in this investigation.

Data Collection

Instrumentation

In this investigation, there were four instruments used to measure psychological distress and social support in bereavement; the Norbeck Social Support Questionnaire, the Goldberg General Health Questionnaire, Widow Interview Guide I and Widow Interview Guide II. Each is discussed below.

The Norbeck Social Support Questionnaire

The Norbeck Social Support Questionnaire (NSSQ) is a self-report questionnaire (Appendix E) designed to measure multiple dimensions of social support based on Kahn and Antonucci's, (1980) definition of social support. Kahn and Antonucci define social support as interpersonal transactions provided through a convoy. These transactions are termed the functional properties of social support such as affect, affirmation and aid. The concept of convoy (the vehicle through which social support is provided) is measured through the network properties of social support. In the NSSQ these network properties are combined in a Total Network subscale score which measures number in network, duration of relationships and frequency of contact with network members. The functional properties of social support are combined in a Total Functional subscale score which measures affect, affirmation and aid.

Scores for Total Network subscale are computed by summing the number in network, the duration of relationship

score (summation of codes [1-5] describing the duration of the relationship with each member of the network) and the frequency of contact score (summation of codes [1-5] describing the frequency of contact with each member of the network). Scores for Total Functional subscale are computed by summing the scores on affect (summation of codes [1-5] describing the affect given by each member of the network), affirmation (summation of codes [1-5] describing the affirmation given by each member of the network) and aid (summation of codes [1-5] describing the aid given by each member of the network). Scores for the three network properties and the three functional properties are derived from ratings made by the subject for each person in the personal network. Descriptive data (frequency distributions) regarding sources of support can be calculated for the network as a whole and for specific subscales and variables. Because the individual's convoy can change over time, questions regarding recent losses of network members are included in the NSSQ as a variable of secondary interest in the study of social support.

The instrument has demonstrated both high test - retest reliability (functional and network item range: .85 to .92; loss items range: .71 to .83) and internal consistency (functional .72 and .98; network .88 to .96; loss .54 to .68) with specific populations (Group I, n = 75 graduate students in nursing; Group II, n = 60 senior nursing students). The instrument appears to be free from the social desirability

response bias. The basis for content validity was the explicit use of conceptual definitions of social support (Kahn & Antonucci, 1980) and network properties (Barnes, 1972) in item generation. Evidence for concurrent validity (n = 55 female nursing graduate students) was obtained through moderately high correlations (.35 to .41 for functional components; .24 to .32 for network properties) with another questionnaire purported to measure social support, the Personal Resource Questionnaire (Brandt and Weinert, 1981). The NSSQ was found to have been used in only one study of widowhood (Kirschling, 1984). While the NSSQ has been used in other studies, it was found to have relatively low correlation (r = .24) with the Kirschling Support Questionnaire (KSQ). The NSSQ takes approximately 15 to 20 minutes to complete.

Since the publication of the revised instrument and scoring instruction (Norbeck et al., 1982), the authors suggested a minor change in scoring. For the items on affect, affirmation and aid, the 5 point rating scale has been converted to a 0-4 scale, rather than a 1-5 scale. This is because the rating of "1" equals "not at all" (no support) from that network member and the "1's" continue to be added to the score, thereby artificially inflating the total amount of support. The authors felt that this conversion will slightly increase the accuracy of the intended ratings.

Reliability of the NSSQ in the Investigation

The reliability of the NSSQ was established using Cronbach's Alpha. The Alpha coefficient obtained for the network properties was .86 for Interview I and .86 for Interview II. The Alpha coefficient for the functional properties was .98 for Interview I and .98 for Interview II.

The Goldberg General Health Questionnaire

The General Health Questionnaire (GHQ) was intended as the primary standardized measure of physical and psychological response to bereavement. The self-administered GHQ (Appendix F) was developed by Goldberg to screen for non-psychotic psychiatric illness among patients coming to general practice (Goldberg, 1972). The GHQ consists of thirty questions about psychological distress or altered behaviour and takes approximately 5 - 10 minutes to complete. For each item the respondent is asked to compare his recent state with his usual state, and distress or altered behaviour is counted as being present if it is being experienced 'more than usual'. The GHQ covers symptom areas such as anxiety/insomnia, depression, anhedonia, anergic and social dysfunction as well as items dealing with role satisfaction and outwardly observable behaviour. The GHQ generates a score between 0 and 30 (Goldberg, 1972).

A score of 5 or more on the 30 question GHQ indicates a level of distress sufficient to warrant further psychiatric

assessment (Goldberg, 1978). Vachon (1979) labelled those widows who scored 0 to 4 as low distress and those widows 5 and above as high distress. Andrews et al. (1978) used the 20 question version (N = 863 suburban adults) with the cutoff point for "psychological impairment" between 3 and 4. Studies by Goldberg (1978) and Goldberg et al. (1976) demonstrated that the GHQ score correlates fairly well with independent clinical assessment (N = 247; r = .70) and with scores on an early 35 item version of the Hopkins symptom distress checklist (SCL-90) (N = 244 patients; r = .78).

Reliability of the GHQ in the Investigation

The reliability of the GHQ was established using Cronbach's Alpha. The Alpha coefficient obtained for the GHQ at Interview I was .94 and for Interview II was .83.

Widow Interview Guide I and II

At the initial interview which took place within the first three to six months of bereavement, the Widow Interview Guide I was used. This instrument, which was constructed by the investigator, included questions on the personal and background characteristics, the physical and psychological characteristics and the social characteristics of the widow during the first six months of bereavement. The guide also contained questions regarding the circumstances surrounding the husband's final illness, presence or absence of warning

concerning the impending death, whether each of the spouses knew death was coming, whether they communicated about this and whether or not communication made a difference. Some of the questions in the interview guide were designed to elicit information similar to that on the standardized instruments to allow some consistency check. This may have been an artificial consistency check however, as the data collected during the interview could have infected the response ratings on the standardized instruments.

The second interview used the Widow Interview Guide II, which took a retrospective look at the coping strategies employed in the intervening period, another look at utilization of social supports, the physical and psychological health characteristics and the social characteristics of the widow.

Widow Interview Guides I and II both ended with an open-ended question to permit expression of concern generated by the interview. The investigator was aware of the problem of "observer decay" and attempted to approach each interview fresh and relaxed in recording actual observations.

<u>Reliability of the Widow Interview Guides</u>

The investigator conducted all interviews. Every third interview was tape recorded to allow for assessment of interviewer bias and help ensure the reliability of the data.

During Interview I, the section on the physical and psychological health characteristics was used as it was

considered by the investigator to be non-threatening to the widow. This tape recording took approximately 15 - 20 minutes. During Interview II, the retrospective view of the widow's first year of bereavement was tape recorded. This section took longer to tape record (i.e. 30-35 minutes), as it consisted of open-ended questions.

Categories were constructed for scoring in relation to the major construct of psychological distress. An independent rater reviewed the taped interviews for purposes of establishing inter-rater reliability. Both the investigator and the independent rater reviewed one taping to discuss any problems. Inter-rater reliability was established as .85 for Interview I. As this was considered adequate for reliability of the Widow Interview Guide, Interview II was not tested for inter-rater reliability. Not all information was available on the taping, as the feelings and non-verbal communication conveyed a great deal to the investigator.

The reliability scores for all the instruments used in the investigation are displayed in Table 5.

Procedures

The initial interview took place immediately after written consent was obtained. The timing for the second interview to occur approximately six months later was discussed at the end of the first interview. These tentative arrangements

TABLE 5

Reliability Scores[a] for Investigation's Instruments During the First Year of Bereavement (N = 30)

Instrument	Interview I	Interview II
Goldberg (GHQ)	.94	.83
Norbeck (NSSQ)		
Total Network Subscale	.86	.86
Total Functional Subscale	.98	.98
Widow Interview Guide I (20 minute segment)	.85	

a Cronbach's Alpha

were confirmed by telephone two weeks prior to the final interview. While it was desirable to have a six month follow-up in this study design, there was some flexibility of time as long as both interviews were completed within the first year of bereavement (i.e. Interview I completed in the first three to six months; Interview II completed in the last nine to twelve months). Most of the interviews were conducted in privacy and without interruption. On two occasions, younger children were present during a portion of the interview. During both occasions, the women were agreeable to the arrangement. The investigator began each interview with a brief introduction (Appendix C and D). When a need for nursing and other services became evident during the interview, immediately following the interview, the subject was asked for permission to make a referral to the appropriate persons.

During the pre-test, the investigator observed that at the onset of the interview the widow had a tendency to initiate discussion about her husband and the nature of the death event. To afford the widow an opportunity to discuss her husband and the nature of the death event early in the interview, the investigator decided to use the Widow Interview Guide I and II as the first instruments in the interview. Thus the ordering of the instruments for both interviews of the investigation was Widow Interview Guide I or II, the Goldberg General Health Questionnaire and the Norbeck Social Support Questionnaire.

The women's eagerness to talk to the investigator was apparent in both interviews. Several women telephoned the investigator more than once to give her "better" directions to their homes. Before the time for Interview II, other women telephoned the investigator rather than waiting for her to call them. The women seemed to have a need to talk about their recent loss and to work through their feelings. This need was reflected in the time needed for both interviews. Although the interview was expected to take 60 - 90 minutes to complete, most women took advantage of the opportunity to share some immediate concerns. Following the semi-structured interview, the subject was expected to complete the social support and psychological distress instruments. These took an additional 20-30 minutes. These were tested instruments with validity and reliability in adult populations established through other studies. Mean interview time for Interview I was 123.16 minutes (S.D. 43.5) with a range of 65 - 285 minutes. Mean interview time for Interview II was 111.33 minutes (S.D. 31.54) with a range of 60 - 190 minutes.

Interview II followed essentially the same pattern as the first and took the same amount of time. The same standardized instruments were used. The difference in the two semi-structured interviews was the retrospective component found in the second Widow Interview Guide which provided a re-examination of the first year of bereavement.

Pre-test

A pre-test, using the instruments of the investigation and following the protocol which required 6 months between interviews, was conducted with three subjects prior to the start of the actual data collection for the study. This test indicated that in general questions were understandable and acceptable to the subjects.

Data Analysis

The Statistical Package for the Social Sciences SPSS (Nie, Hull, Jenkins, Steinbrenner, & Brent, 1982) and the $SPSS^{x}$ Users Guide (SPSS Inc., 1983) computer programs were used for statistical analysis of the data. Both descriptive and inferential statistics were used in the investigation's results. Hypotheses were tested with the parametric statistic (Pearson product-moment correlation coefficient) and the non-parametric statistic (Spearman rank order correlation coefficient). The level of significance for the test of hypotheses was .05; results were deemed statistically significant if $p < .05$.

Frequency distributions were constructed to describe the personal and background characteristics, the physical and psychological health characteristics and the social characteristics of the sample. Reliability coefficient (Cronbach's Alpha) was chosen to measure for internal consistency on the standardized instruments: the Goldberg General Health

Questionnaire (GHQ) and the Norbeck Social Support Questionnaire (NSSQ).

In addition, some content analysis was done on the data from the open-ended questions on Widow Interview Guides (I and II). These were used to elaborate the description of the sample and the three investigation variables (psychological distress, perceived social support network and perceived functional social support) and common concerns expressed by the subjects.

Pearson product-moment correlation coefficient displayed the inter-relationships among the major investigation variables from data collected for each subject at 3 - 6 months following the death of the husband and six months later:

A. For each data collection episode, psychological distress was correlated with perceived functional social support and perceived social support network.

B. To compare the investigation variables over the first year of bereavement, scores for the two data collection episodes for each variable (psychological distress, perceived functional social support and perceived social support network) were correlated with each other.

Cross-tabulations were explored on the personal and background characteristics, the physical and psychological health characteristics and the social characteristics of the widow with the major dependent variable psychological distress to determine interrelationships.

Limitations of the Investigation

1. The sample size and the sampling method restricted generalization of the findings.
2. Extraneous variables such as coping responses, previous social support and resolution of previous marital conflict which could have affected the subjects' responses were not controlled.
3. Information requested in the first interview may have resulted in a re-definition of the subjects' expectations following the interview and may have influenced the subjects' responses in the second interview.
4. The Widow Interview Guides I and II used in the investigation were not previously tested.

CHAPTER IV

THE RESULTS

In this investigation, the sample was 30 women aged 45-64 who were interviewed at two time periods during the first year of bereavement. Results are presented in three sections: 1) Characteristics of the sample; 2) Relationships between psychological distress and social support; and 3) Variables other than perceived social support affecting psychological distress.

Case studies will be presented that help to integrate the major findings and add a personal flavour to the investigation and to the phenomenon of psychological distress and social support in bereavement.

Characteristics of the Sample

Background and Personal Characteristics

The background and personal characteristics of the women are displayed in Table 6. The median age of the women was 56 years with an age range of 45-64. The majority of the women were born in Newfoundland (n = 24). Those born outside Newfoundland came from other provinces of Canada, the British Isles, Yugoslavia and Spain, and all the women had English as a primary language. Fifteen women had not finished high school. Almost half of the women (n = 14) were Roman Catholic. Other religious preferences mentioned were Anglican, United Church, Pentecostal and Moslem. Twenty-one women were attending

TABLE 6

Background and Personal Characteristics of the Sample at Six Months of Bereavement (Interview I) (N = 30)

Variable	Category	Frequency
Age (years)	45 - 50	9
	51 - 55	5
	56 - 60	8
	61 - 64	8
Place of birth	Newfoundland	24
	Other province	2
	Outside Canada	4
Educational level	Not finished high school	15
	Finished high school	3
	Post-secondary education	8
	Some university	2
	Finished university	2
Number of siblings (alive)	0	2
	< 5	13
	5 - 10	12
	> 10	3
Position in primary family (n = 28)	Youngest	8
	Middle	10
	Oldest	10
Parent still living	No	15
	Yes	15
Religious preference	Roman Catholic	14
	Anglican	10
	United Church	4
	Pentecostal	1
	Moslem	1
Attendance at religious services	Never	3
	Yearly	4
	Monthly	2
	Weekly	18
	Daily	3

Variable	Category	Frequency
Length of marriage (years)	10 - 15	3
	16 - 20	2
	21 - 25	2
	26 - 30	3
	31 - 35	7
	36 - 40	8
	41 - 45	4
	> 45	1
First marriage	No	2
	Yes	28
Children alive	0	1
	< 5	18
	5 - 10	9
	> 10	2
Children under 18	0	21
	< 5	9
Present work status	Retired or home	18
	Student	2
	Part-time work	2
	Full-time work	8
Occupation (n = 10)	Managerial, administrative	1
	Medical and health	1
	Art, literature and recreation	1
	Clerical	3
	Sales	2
	Service	2
Future work plans (continuing working or seeking employment	No	16
	Yes	14
Perception of cause of husband's death	Diseases of heart	13
	Malignant tumors	6
	Vascular lesions (CNS)	3
	Unknown, ill defined	8
Sudden death vs chronic illness	Sudden death	15
	Chronic illness	15

Variable	Category	Frequency
Discussed impending death with husband	No	24
	Yes	6
Living arrangements	Alone	8
	With others	22
	House	28
	Apartment	2
Experienced death before	No	5
	Yes	25
$ Income before death	< 13,000	5
	13,001 - 14,999	4
	15,000 - 19,999	0
	20,000 - 24,999	6
	25,000 - 29,999	3
	30,000 - 49,999	10
	> 50,000	1
$ Income after death of husband	< 13,000	14
	13,001 - 14,999	3
	15,000 - 19,999	7
	20,000 - 24,999	5
	25,000 - 29,999	0
	30,000 - 49,999	1
	> 50,000	0
Widow driving a vehicle	No	15
	Yes	15

religious services at least once a week during the first 6 months of bereavement (Interview I).

The length of marriage for the women ranged from 11-46 years with a median of 33.5 years. For 28 women, this was their first marriage. Eleven women had more than 4 children alive and 9 of the women had children under 18 still living at home. Twelve women were either back at school or employed outside the home in a full-time or part-time capacity. Eighteen of the women were full-time homemakers. Twenty-two women were living with others, usually with their children. Twenty-eight of the women lived in their own homes, in which they had spent most if not all of their married lives. Only 2 women lived in apartments and they lived alone.

Most of the husbands died of diseases of the heart (n = 13) with a median age at death of 61.5. Fifteen of the deaths were sudden, such as from massive heart attacks and the other 15 deaths involved a chronic illness. The length of time of the husband's illness ranged from 0 - 99 months with the median being 36 months. Five of these men had been hospitalized more than 12 months. The widows of these men indicated at Interview I that although they were experiencing some relief regarding their husband's death, they missed the routine of visiting the hospital 2-3 times per week. Thirteen of the husbands were employed at the time of their death. Table 7 displays the background and personal characteristics of the widows' husbands.

TABLE 7

Background and Personal Characteristics of the Deceased Husbands (N = 30)

Variable	Category	Frequency
Age at death (years)	45 - 50	3
	51 - 55	4
	56 - 60	5
	61 - 65	16
	65 - 70	2
Place of birth	Newfoundland	27
	Outside Canada	3
Number of siblings (alive)	0	3
	< 5	16
	5 - 10	9
	> 10	2
Husband's occupation (n = 22)	Managerial, administrative	6
	Natural Sciences, engineering and mathematics	1
	Medical and health	2
	Sales	3
	Service	4
	Machining	1
	Product fabricating, assembling and repairing	1
	Construction trades	4
Work status at time of death	Retired	8
	Unemployment, disabled	9
	Employed	13
First marriage	No	0
	Yes	30
Length of last hospitalization (months)	0	15
	< 6	10
	6 - 12	0
	> 12	5
Length of time ill before death (months)	0	7
	< 6	0
	6 - 12	5
	> 12	18

Only six women had discussed impending death or death in general with their husbands. These six women had mainly discussed funeral arrangements with their husbands, not their feelings regarding death. Many women stated that they had sensed that something was going to happen or that their husbands were unwell. Twenty-five of the women had experienced death before, usually that of one or both parents.

An interesting finding of the investigation was that 15 of the women did not drive. Living with others (husband and adult children) had not provided an opportunity or a need to learn to drive.

The women's family income was varied. Nine women had income below the poverty level (< $19,000) before the husband's death whereas 24 women had that income level after. Only 1 woman had what might be considered upper middle class income (> $50,000) before the death of her husband and no woman had this income after the death of her husband. The mean monthly income for the women in the sample before the death of their husbands was $2,081 whereas the mean monthly income of the women in the sample after the death of their husbands was $1,240. There was no relationship between income and living alone versus living with others. It is possible that most of the women in the sample have fewer financial concerns than other widows from outside the province because based on national statistics, the percentage of homeowners in Newfoundland

(81%) is greater than the national average (62%) (Canada Year Book, 1980-1981).

Psychological Distress

To describe the psychological distress of the women, the investigation utilized a standardized instrument, the Goldberg General Health Questionnaire (GHQ). The cumulative score on this instrument was a measure of the psychological distress the woman was experiencing during the first year of bereavement.

The minimum score possible on the Goldberg General Health Questionnaire (GHQ) is 0, whereas the maximum is 30. On the 30 item GHQ, a score of 5 or more was accepted as the cut-off point indicating a level of distress sufficient to require further assessment. The Interview I scores ranged between 0 and 23, with a median of 4, a mean of 6 and standard deviation of 7. The Interview II scores ranged between 0 and 11, with a median of 2, a mean of 3 and standard deviation of 3. Table 8 shows the grouped scores for the sample for Interviews I and II.

The women's scores on the GHQ (psychological distress level) at Interview I and II and the amount of change are displayed in Table 9. Women with initial low scores for psychological distress continued to report low scores at Interview II (the end of the first year of bereavement) whereas women with high scores for psychological distress reported lower scores at Interview II. This was also found

TABLE 8

Frequency Distribution of the Goldberg General Health Questionnaire (GHQ) Scores of the Sample During the First Year of Bereavement (N = 30)

GHQ Scores	Frequency	
	Interview	
	I	II
0 - 4	15	25
5 - 10	10	4
11 - 15	0	1
16 - 20	3	0
21 - 30	2	0

TABLE 9

Change in the Women's Psychological Distress Scores During the First Year of Bereavement

Client	GHQ Score Interview I	GHQ Score Interview II	Change
001	8	2	- 6
002	3	5	+ 2
003	0	2	+ 2
004	1	4	+ 3
005	8	2	- 6
007	7	1	- 6
008	2	1	- 1
009	3	3	0
010	0	0	0
011	0	0	0
012	16	11	- 5
013	7	10	+ 3
014	3	1	- 2
015	18	0	-18
016	23	0	-23
017	1	0	- 1
018	8	9	+ 1
019	10	10	0
020	2	0	- 2
021	0	0	0
022	20	0	-20
023	23	2	-21
025	0	0	0
026	9	0	- 9
027	6	1	- 5
028	1	4	+ 3
030	8	4	- 4
031	0	2	+ 2
032	0	0	0
033	5	4	- 1

Note: - Decrease
+ Increase

in Vachon's study (1979), where an initial GHQ score was found to be a predictor of adaptation to bereavement for women during the first two years of bereavement.

Fifty percent of the women (n = 15) of the sample in this investigation at an early stage of their bereavement had a degree of psychological distress similar to that reported in other studies (e.g. Vachon et al., 1982) sufficient to interfere with their normal healthy functioning (GHQ score > 5). During the first year of bereavement, 37% of the total sample (n = 11) had a decline in their scores to a lower psychological distress level. Four of these women reported very high psychological distress (scores 18+) at Interview I and very low psychological distress (scores 0-2) at Interview II; concurrent stressors such as financial worries and family problems were present at Interview I for these women and these stressors were somewhat resolved at Interview II.

Almost all of the women who reported low or no psychological distress (GHQ scores 0-4) in response to their husband's death continued to report low or no psychological distress over the first year of bereavement. Five women reported no psychological distress at all during the first year of bereavement. Nine of the women reported low psychological distress scores throughout the first year while one woman's psychological distress score increased from low to high during the first year of bereavement. This group of women

reporting low psychological distress scores had a GHQ mean score of 1 throughout the first year of bereavement.

In the sample, 13% of the women (n = 4) reported high initial GHQ scores at Interview I. They reported these high scores again at the end of the first year of bereavement. This group of women reporting high psychological distress scores throughout the first year of bereavement had a GHQ mean score of 12 initially which decreased to 9 at the end of the first year of bereavement (which is still above the cut-off of 5 indicating possible psychiatric difficulty). At the end of the first year of bereavement 5 women reported high psychological distress (GHQ score of > 5) and over half of these women (n = 3) had scores of 10+.

Further analysis of the change in the level of psychological distress during the first year of bereavement indicated that 16 women reported a decrease in their psychological distress scores, 7 women increased their psychological distress scores, and 7 women reported the same scores during Interview I and II. For the women reporting an increase in psychological distress, this change in the level of psychological distress was due to events other than the bereavement process that were occurring in their lives.

On the basis of the literature review, it was hypothesized that score on psychological distress experienced by widows at the first three to six months of bereavement would be

positively correlated with score on psychological distress experienced by widows six months later. The product moment correlation for psychological distress between Interview I and II was .15 ($p = .22$), a statistically non-significant positive relationship. It can be said that for this sample that psychological distress at the first three to six months of bereavement did not predict the level of distress six months later.

Physical and Psychological Health Characteristics

The physical and psychological health characteristics of the women are outlined in Table 10. At Interview I, ten women reported their health as worse since their husbands died. During Interview II, 8 women of the sample continued to report their health as worse. Twelve of the women at Interview I had taken or were taking either tranquilizers or sleeping pills since their husbands had died. These women did not indicate if this usage was a continuation of previous usage or newly initiated usage of these medications. During Interview II, 7 women of the sample were still taking these medications.

Twenty-one of the women stated that there were things that they found difficult to do. At Interview I, 15 women were having difficulty making decisions and 10 women were encountering

and Psychological Health Characteristics of the (N = 30)

	Category	Interview I Freq.	Interview II Freq.
ince husband	Worse	10	8
	Just the same	20	11
	Better		11
onal help sician	No	14	14
	Yes	16	16
onal help chiatrist	No	27	28
	Yes	3	2
onal help usband died	No	18	
	Yes	12	
uilizers ing pills ath of husband	No	15	23
	Yes	12	7
	Offered but not taken	3	
t there are hat are t to do now	No	9	17
	Yes	21	13
ty concentrating	No	18	12
	Yes	3	1
	No response[a]	9	17
ty making s	No	6	9
	Yes	15	4
	No response	9	17
ty working of home)	No	19	12
	Yes	2	1
	No response	9	17
ty with es of ving (ADL)	No	11	2
	Yes	10	11
	No response	9	17

Variable	Category	Interview I Freq.	Interview II Freq.
Difficulty meeting people	No	16	13
	Yes	5	0
	No response	9	17
Having difficulty with eating	No	22	29
	Yes	8	1
Having difficulty with sleeping	No	13	19
	Yes	17	11
Drinking	No	17	18
	Less	2	0
	The same	10	12
	More	1	0
Smoking	No	18	20
	Less	2	2
	The same	7	6
	More	3	2
Weight (n = 29)	Lost	15	5
	Remained the same	9	19
	Gained	5	6

a. No response refers to those women who responded negatively to there are things that are difficult to do now.

difficulty with activities of daily living. During Interview II, only 4 women of the sample were having difficulty making decisions while 11 women of the sample were still encountering difficulty with activities of daily living. One widow's comments during Interview II paint a clear picture:

> I feel so alone - what is there to look forward to - who is there to cook for or to clean the home for. My father and son still live with me but it is not the same. I still feel very much alone and it is an effort to do anything. My husband gave me the reassurance and the reason to keep going and living - I don't have that now and yet I must keep going. Everyone tells me to keep my spirits up so I feel I must keep going even though I feel like crying all the time.

All studies of bereavement refer to sleep disturbances such as insomnia and nightmares as some of the frequently encountered psychological symptoms in grief reactions; therefore these symptoms are not unexpected among newly bereaved widows. Seventeen women (57%) expressed difficulty with sleeping at Interview I. Thirteen of these women were reporting high psychological distress scores. During Interview II, 11 women (37%) were still reporting having difficulty with sleeping. All of the women reporting high psychological distress scores at Interview II (n = 4) were in this category. Two women commented on their sleeping during Interview II:

> I cannot sleep through the night. I find myself dozing for short naps only to see the clock as it strikes each hour through

> the night. I wake very early in the morning and spend the time tossing and turning until it is time for me to get up. I find that I am in a state of constant tiredness day in and day out.
>
> I never sleep - I only cat nap. I am always tired. I think this may be the night that I will sleep and then I watch the clock every minute. During this time, my head is filled with many thoughts running at 100 miles per hour. I never rest in the day because I want to try to sleep at night. I tried sleeping pills but they put me asleep only to wake a few hours later with a heavy hangover.

Over half of the women did not smoke or drink. Eight women during Interview I reported having difficulty with eating while only one woman reported this difficulty during Interview II. Fifteen women at Interview I stated that they had lost weight since their husbands had died and 5 women reported continuing to lose weight at Interview II. As it was the intent of the question to evaluate the widow's health during the interviews, it is assessed that this loss of weight was due to the bereavement process, not deliberate for pride or pleasure. Table 11 outlines the frequency with which each specific difficulty was reported; making decisions, activities of daily living, sleeping and weight were the most frequently reported at Interview I and at Interview II. The findings in the investigation indicate that certain difficulties were reported more frequently than others.

TABLE 11

Frequency of Difficulties Encountered by the Sample During the First Year of Bereavement (N = 30)

Difficulty	Frequency mentioned[a]	
	Interview	
	I	II
Concentrating	3	1
Making decisions	15	4
Working (outside of home)	2	1
Activities of daily living	10	11
Meeting people	5	0
Eating	8	1
Sleeping	17	11
Drinking	1	0
Smoking	3	2
Weight		
gain	5	6
loss	15	5

a Some women mentioned more than 1 difficulty.

Sixteen women (53%) in this investigation were seeing their physician during the first year of bereavement. The women had consulted their physicians because of headaches, dizziness, muscular aches, menstrual irregularities, loss of appetite and sleeplessness.

One woman had been admitted to a psychiatric unit within the first six months of bereavement for depression. Two women had sought professional psychiatric help for symptoms of depression. One woman commented on her reason for seeking psychiatric help:

> My daughter and son wanted me to see a psychiatrist as I was constantly upset and I was saying such things as: I don't want to live any longer - I wish I was dead so that I could be with my husband. I saw the psychiatrist only once and he suggested that I take some anti-depressants. I said that when my husband was so ill, I never took anything so why should I take them now. I did feel better though after talking with him.

Social Support Network

To describe the social support network of the women, the investigation utilized a standardized instrument, the Norbeck Social Support Questionnaire (NSSQ). Total Network subscale scores reflect the perceived social support network reported by the women during Interviews I and II.

The minimum score possible on the Norbeck Social Support Questionnaire (NSSQ) for the Total Network subscale score is 0, whereas the maximum is 264. The range of scores at Interview I was 41 to 252, with a mean of 124 and standard deviation

of 58. At Interview II, the range of scores was 59 to 245, with a mean of 131 and standard deviation of 54. Table 12 shows the scores for the sample for Interview I and II.

All the women indicated at least four persons in their networks at both Interview I and II; overall, the range of numbers listed in network at Interview I was 4 to 24, with a mean of 12.5 and a standard deviation of 6. At Interview II, the range was 6 to 24, with a mean of 13 and a standard deviation of 5.

The source of support category reported by all of the women was family or relatives (100%) (see Table 13). In contrast, few women listed work or school associates, health care providers, counsellor or therapist as sources of support. Overall, the women in the sample reported no change in the support category of family or relatives from Interview I to Interview II. The women reported an increase in the support category of work or school associates from Interview I to Interview II as some of the women returned to work and to school. The investigator found that there was some overlap in some of the categories as some members of the women's families were deemed friends rather than family or other widows. One woman made the following comment during Interview I:

> My best friend is my sister-in-law who is also a widow. We go everywhere together and I confide many things to her that I would not even share with my children nor my husband when he was alive.

TABLE 12

Frequency Distribution of the Total Network Subscale Scores on NSSQ of the Sample by Quartile During the First Year of Bereavement (N=30)

Total Network subscale scores	Frequency	
	Interview	
	I	II
1 - 66	4	2
67 - 133	16	18
134 - 200	7	5
201 - 264	3	5

TABLE 13

Mean Number of Persons and Range in Each Source of Support Category and Percentage of Sample Listing Each Source of Network List (N = 30)

Source of support category	Interview I			Interview II		
	x	Range	%	x	Range	%
Family or relatives	7.1	1-17	100.0	7.7	0-18	100.0
Friends	4.0	0-13	97.0	3.5	0-8	93.0
Work or school associates	.03	0-1	3.0	.4	0-5	17.0
Neighbours	.6	0-9	20.0	.7	0-4	33.0
Health care providers	.2	0-3	13.0	.3	0-5	17.0
Counsellor or therapist	.1	0-3	3.0	.1	0-2	3.0
Minister/priest /rabbi	.5	0-3	37.0	.5	0-3	40.0

The women reported the clergy as a support category consistently throughout the first year of bereavement. Appendix G displays the network of this Newfoundland sample during the first year of bereavement. The majority of the women in the sample reported they had known network members 5 years or more.

Many of the responses to the Widow Interview Guides I and II, which examined the social characteristics of the women, are consistent with the responses to the Norbeck Social Support Questionnaire, which quantitatively measured the women's perceived social support network.

Functional Social Support

To describe the functional social support of the women, the investigation utilized a standardized instrument, the Norbeck Social Support Questionnaire (NSSQ). Total Functional subscale scores (calculated by summing the scores on affect, affirmation and aid) reflect the perceived functional social support reported by the women during Interviews I and II.

The minimum score possible on the Norbeck Social Support Questionnaire (NSSQ) for the Total Functional subscale is 0, whereas the maximum is 576. The range of scores at Interview I was 68 to 523, with a mean of 236 and standard deviation of 130. At Interview II the range of scores was 87 to 487, with a mean of 252 and standard deviation of 105. Table 14 shows the scores for the sample for Interview I and II.

TABLE 14

Frequency Distribution of the Total Functional Subscale Scores on NSSQ of the Sample by Quartile During the First Year of Bereavement (N=30)

Total Functional subscale scores	Frequency Interview I	Frequency Interview II
1 - 144	8	6
145 - 289	15	15
290 - 434	3	7
435 - 576	4	2

Overall, the sample reported more affect, affirmation and aid (the variables composing functional social support) at Interview II than at Interview I (See Appendix I). The greatest increase in the perceived functional social support scores was seen in the affirmation variable scores, particularly the scoring on confidence (how much can you confide in this person).

A comparison of mean scores for the variables affect, affirmation and aid on the NSSQ was revealing. In general, the women gave their network members the greatest score for affect [making them feel liked or loved (question 1)] during Interview I and for providing aid [borrow $10, a ride to the doctors or some other immediate help (question 5)] during Interview II. Conversely, the women gave their network members the lesser score for providing aid [if you were a patient (question 6)] during Interview I and again during Interview II.

On the basis of the literature review, it was hypothesized that: 1) Score on perceived social support network at the first three to six months of bereavement will be negatively correlated with score on perceived social support network six months later, 2) score on perceived functional social support at the first three to six months of bereavement will be negatively correlated with score on perceived functional social support six months later, 3) score on perceived social support network at the first three to six months of bereavement will be

positively correlated with perceived functional social support at the first three to six months of bereavement and 4) score on perceived social support network during the second six months of bereavement will be positively correlated with perceived functional social support during the second six months of bereavement.

The correlations of perceived social support network between Interviews I and II and perceived functional social support between Interviews I and II are shown in Table 15. As can be seen from the table, there was a positive correlation between perceived social support network at Interviews I and II. There was also a positive correlation between perceived functional social support at Interview I and II. These correlations are in the opposite direction from those hypothesized, therefore the original hypotheses are rejected. However, with the level of significance set at .05, alternate hypotheses regarding the positive correlation of the components of social support over time were accepted. It can be said then that for this sample there was a statistically significant positive correlation between perceived social support network at the first three to six months of bereavement and six months later. It can also be said that for this sample there is a statistically significant positive correlation between perceived functional social support at the first three to six months of bereavement and six months later.

TABLE 15

Product-Moment Correlations Between Perceived Social Support Network Scores at Interviews I and II and Between Perceived Functional Social Support Scores at Interviews I and II.

Variable	Correlation
Perceived social support network	.45**
Perceived functional social support	.47**

** $p < .01$

The correlations between perceived social support network and perceived functional social support at Interviews I and II are shown in Table 16. It can be seen that there was a very strong positive correlation between perceived social support network and perceived social support at Interviews I and II. Given that the level of significance was set at .05, the last two hypotheses were accepted. It can be said then, that for this sample there was a statistically significant positive correlation relationship between perceived social support network and perceived functional social support both at the time of Interview I and at the time of Interview II.

Social Characteristics

The social characteristics of the women are outlined in Table 17. Twenty-eight women were seeing and talking with close friends almost daily at Interview I. This decreased slightly at Interview II. Thirteen women were seeing and talking with husband's friends at least once a week at Interview I. This decreased to once a month by Interview II. Almost all the women, 25 during Interview I and 26 during Interview II were seeing and talking with family members at least once a week. Of these women, more than half (n = 15 at Interview I; n = 20 at Interview II) were seeing or talking with family members on a daily basis. Two-thirds of the sample were seeing or talking with members of husband's family at least once a week at both Interview I and II.

TABLE 16

Product-Moment Correlations Between Perceived Social Support Network Scores and Perceived Functional Social Support Scores at Interview I and at Interview II.

Variables perceived social support network and perceived functional social support	Correlation
Interview I	.94**
Interview II	.95**

** $p < .01$

The individuals most frequently seen or talked to by the women during Interviews I and II are displayed in Table 18. The widow was seeing and talking most frequently with her sister, her sister-in-law, her daughter and her son, and with her neighbours. As shown in Table 17, only 7 women reported during Interview I that they had made any new friends and these friends were mainly related to school or to work.

Twenty-five women reported that they felt closer to certain people since their husbands had died (See Table 19). During Interview I the widow reported her family as the people she had gotten closer to since her husband had died; friends were reported more frequently at the end of the first year of bereavement. At Interview I, fifteen women were seeing some people less frequently than before their husbands had died and this decreased slightly (n = 13) by Interview II (see Table 17).

Specific individuals the widow turns to to discuss any problems she might have are identified in Table 20. Twenty-seven of the women turned to their families for this purpose. The widow reported her family most frequently as the group who were most helpful to her <u>at</u> the time of her husband death, while the widow's friends were reported most frequently as the group who had been especially helpful <u>since</u> her husband died. The widow reported friends and neighbours as individuals most frequently seen by her during Interviews I

TABLE 17

Social Characteristics of the Sample (N = 30)

Variable	Category	Interview I Freq.	Interview II Freq.
See and talk with close friends	No	2	1
	Yes	28	29
How often	Once a week	8	13
	Daily	20	16
	No response[a]	2	1
See and talk with husband's friends	No	12	17
	Yes	18	13
How often	Once a month	5	8
	Once a week	11	3
	Daily	2	2
	No response	12	17
See and talk with family members	No	3	0
	Yes	27	30
How often	Once a month	2	4
	Once a week	10	6
	Daily	15	20
	No response	3	
See and talk with members of husband's family	No	10	7
	Yes	20	23
How often	Once a month	8	10
	Once a week	9	11
	Daily	3	2
	No response	10	7

Variable	Category	Interview I Freq.	Interview II Freq.
Made any new friends	No	23	21
	Yes	7	9
Who:			
Neighbours	No	6	9
	Yes	1	0
	No response	23	21
School or work friends	No	3	1
	Yes	4	8
	No response	23	21
Other widows	No	4	8
	Yes	3	1
	No response	23	21
Closer to certain people	No	5	9
	Yes	25	21
Who:			
Family	No	11	16
	Yes	14	5
	No response	5	9
Friends	No	12	3
	Yes	13	18
	No response	5	9
Other widows	No	21	21
	Yes	4	0
	No response	5	9
See some people less frequently	No	15	17
	Yes	15	13
Who:			
Husband's family	No	11	12
	Yes	4	1
	No response	15	17
Husband's friends	No	3	1
	Yes	12	12
	No response	15	17
Widow's family	No	15	13
	No response	15	17

Variable	Category	Interview I Freq.	Interview II Freq.
Widow's friends	No	11	9
	Yes	4	4
	No response	15	17
Turn to anyone in particular to discuss problems	No	3	2
	Yes	27	28
Who:			
Widow's family	No	4	9
	Yes	23	19
	No response	3	2
Widow's friends	No	20	17
	Yes	7	11
	No response	3	2
Other widows	No	27	27
	Yes	0	1
	No response	3	2
Was there anyone especially helpful to you at the time your husband died	Yes	30	
Is there anyone especially helpful to you since your husband died	Yes		30
Who:			
Widow's family	No	11	16
	Yes	19	14
Husband's family	No	25	27
	Yes	5	3
Widow's friends	No	20	13
	Yes	10	17
Others	No	25	29
	Yes	5	1

		Interview	
		I	II
Variable	Category	Freq.	Freq.
Who took care of funeral arrangements	Widow	17	
	Widow's family	1	
	Husband's family	2	
	Children	8	
	Others	2	

a No response refers to those women who responded negatively in the major category.

TABLE 18

Frequency Distribution of Individuals Seen or Talked to by the Sample During the First Year of Bereavement (N=30)

Individual	Frequency mentioned[a] Interview I	II
Close friends		
Neighbours	12	17
Other widows or divorced friends	4	1
Co-workers or activity friends	9	9
Male friend	2	2
Husband's friends		
Business associates or colleagues	6	3
Couple friends	4	4
Neighbours	8	3
Widow's family		
Sister	16	11
Mother, father	5	8
Daughter	11	9
Son	8	15
Brother	5	3
Other (aunt, cousin, granddaughter)	3	1
Husband's family		
Sister-in-law	10	17
Brother-in-law	5	4
Others (mother-in-law, father-in-law, cousins)	3	8

a Some women mentioned more than 1 individual

TABLE 19

Frequency Distribution of Individuals Whom Widow Feels Closer to Since Husband Died During the First Year of Bereavement (N = 30)

Individual	Frequency mentioned[a]	
	Interview	
	I	II
Friends	9	14
Neighbours	6	6
Husband's family		
Sister-in-law	3	3
Other (mother-in-law, brother-in-law)	2	1
Widow's family		
Sister	4	1
Daughter	7	2
Other (brother)	1	

a Some women mentioned more than 1 individual

and II (see Table 18) and individuals whom she turned to discuss any problems she might have (see Table 20).

The importance of children in the support system of the widow cannot be overrated. In this investigation, daughters tended to be more helpful than sons and were relied upon for emotional closeness and comfort. The widows reported their daughters most frequently as the individuals within the widows' family as becoming closer to since their husbands had died. The women reported daughters and friends equally as the individuals whom they turned to discuss any problems they might have (see Table 20).

Sons, on the other hand, were expected to assist in task-oriented duties such as making the arrangements, giving advice and, in some senses, taking over some of the duties of the husband. In this investigation, the widows reported their sons as the individuals within the widow's family most frequently seen by the widow at the end of the first year of bereavement. The women also reported their sons as the individuals who helped them take care of the funeral arrangements (see Table 17). Family ties were not voluntary and were sometimes viewed by the widow as increasing her dependency on her children. One woman commented during Interview I:

> My children are constantly calling to see how I am doing or telling me what I should or should not do. I want to lead my own life, make my own decisions without any interference or I shall end up very dependent on them.

TABLE 20

Frequency Distribution of Individuals Whom Widow Turns to to Discuss Problems During the First Year of Bereavement (N = 30)

Individual	Frequency mentioned[a]
Friends	11
Daughter	11
Son	7
Sister	6
Professional	3
Other (father, brother and sister-in-law)	2

a Some women mentioned more than 1 individual

It was reported in the literature that other components of the support system, such as relatives outside the immediate family and non-family members, including co-workers and professionals, tend to be untapped resources. In this investigation too, there was limited reporting of professionals and relatives outside the immediate family as other components of the support system. Co-workers were often mentioned but only as part of the friendship component. Friends and neighbours provided companionship and shared activities (e.g. bingo, darts, playing cards) with the widow, while children tended not to fill these roles.

Adjustments with friends were sometimes required after the death of the husband, particularly if the couple tended to have couple-friends. In this investigation, a few women indicated that there were changes in their friendship networks. Most of the women continued to consider some married friends as close to them and a few limited their contacts only to women of the same marital status. Many of the women prior to their husband's death were involved in sex segregated activities such as bowling and playing darts on women's leagues and cards and these activities continued during the first year of bereavement.

Relationships Between Psychological Distress and Social Support

Psychological Distress and Perceived Social Support Network

On the basis of the literature review, it was hypothesized that the level of psychological distress experienced by widows will vary with their perception of their social support network during the first year of bereavement. Statistically, score on psychological distress experienced by widows would be negatively correlated with score on perceived social support network during the first three to six months of bereavement and during the second six months of bereavement.

The correlations between psychological distress as measured by the Goldberg General Health Questionnaire (GHQ) and the perceived social support network as measured by the Total Network subscale score on the Norbeck Social Support Questionnaire (NSSQ) are shown in Table 21. The GHQ and the Total Network subscale scores on the NSSQ correlated positively ($r = 0.26$) at Interview I contrary to the prediction. At Interview II, the GHQ and Total Network subscale scores correlated negatively ($r = -.15$), which was predicted. Although the GHQ and the Total Network subscale scores correlated negatively at Interview II, they were not statistically significant. Given that the level of significance was set at .05, these hypotheses concerning the inverse relationships with psychological distress and perceived social

TABLE 21

Correlations[a] Between Psychological Distress as Measured by GHQ and Perceived Social Support Network as Measured by Total Network Subscale on NSSQ During the First Year of Bereavement (N = 30)

Variables psychological distress and perceived social support network	Correlation
Interview I	r = .26 (P = .09)
Interview II	r = -.16 (P = .21)

a Pearson product-moment correlation coefficient

support network during the first three to six months of bereavement and during the second six months of bereavement were rejected. It can be said for this sample that there was no statistically significant relationship between psychological distress and perceived social support network during the first year of bereavement.

To explore the relationship between psychological distress and perceived social support network further, the psychological distress groups and the total network subscale means scores during the first year of bereavement were compared for women with various experiences of psychological distress (high-high, high-low, low-low, low-high). This analysis indicated that all the women (N = 19) except the women experiencing initially high psychological distress which decreased to low psychological distress at the end of the first year of bereavement reported an increase in their perceived social network (see Table 22). These women with high psychological distress which decreased to low psychological distress (N = 11) reported a decrease in their perceived social support network during the first year of bereavement. It may well be that the women in this latter group have been selective regarding whose support they needed and acted accordingly by decreasing their network number or the frequency of support. It may also be that all the women had difficulty in responding to the instruments' questions. The point that women had trouble with the instrument will be discussed more fully later in the thesis.

TABLE 22

Total Network Subscale Mean Scores for Psychological Distress Groups During the First Year of Bereavement (N = 30)

Psychological distress groups	N	Total Network subscale scores Interview I	II
High High	4	110	112
High Low	11	135	126
Low High	1	64	92
Low Low	14	124	141

Analysis of the qualitative data of this investigation offers possible explanations for this finding. Two examples are presented:

> Mrs. A had an initial GHQ of 18 at Interview I which decreased to 0 at Interview II.
>
> At Interview I, she was surrounded by many of her family and friends. She was beginning to make new friends. NSSQ at Interview I revealed that 13 members of her family, 8 friends, 1 co-worker and 2 neighbours were part of her network.
>
> At Interview II, she had met a new male friend, was dating and starting to become "my own person". She was not seeing any of her husband's friends any longer and was very involved with her new male friend much to the dismay of her children and family. She was receiving support from a select few of her family.
>
> NSSQ at Interview II indicated that 4 members of her family and 4 friends were part of her network.

> Mrs. B had an initial GHQ of 23 at Interview I which decreased to 0 at Interview II.
>
> At Interview I, she was surrounded by her family and neighbour friends. She was not seeing her husband's friends, nor had she made any new friends. She was very pre-occupied with her father's health which was deteriorating and she was anxiously waiting to hear of his placement into a nursing home. She felt very close to her neighbour friends. NSSQ at Interview I revealed that 9 members of her family, 12 friends, 1 health care provider and 2 ministers were part of her network.

> At Interview II, she was receiving help with her father's care. She was seeing some of her husband's friends and was still feeling close to her neighbour friends. NSSQ at Interview II indicated that 5 members of her family, 6 friends, 2 neighbours and 2 ministers were part of her network.

Both of these examples reflect consistency between the responses on the Widow Interview Guides I and II and the quantitative measures on the NSSQ. For both of these women, as with the other women who had initially high psychological distress which decreased to low psychological distress at the end of the first year of bereavement, the narrative from the semi-structured interviews did seem to indicate that there was a decrease in the women's network. Although for the sample in general, there appeared to be an increase in the number in the network during the first year of bereavement, as with all of the women, the network changes were individualistic.

The percent of women reporting change in the Total Network subscale scores, Total Functional subscale scores and the network members during the first year of bereavement is displayed in Table 23. Seventeen women reported a decrease in their perception of social support network during the first year of bereavement while 16 women reported an increase in their perception of functional social support during the same period. Only one woman reported her perceived social support

TABLE 23

Percent of Women Reporting Change in Total Network Subscale Scores, Total Functional Subscale Scores and Number in Network During the First Year of Bereavement (N = 30)

Scores	n	Increase	n	Decrease	n	Stayed the same
Total Network subscale	12	40%	17	57%	1	3%
Total Functional subscale	16	53%	13	43%	1	3%
Number in network	11	37%	13	43%	6	20%

network and perceived functional social support to be the same during the first year of bereavement. Thirteen women reported a decrease in the their network members during the first year of bereavement while 11 women reported an increase. Six women reported their network members as staying the same.

<u>Psychological Distress and Perceived Functional Social Support</u>

On the basis of the literature review, it was hypothesized that the level of psychological distress experienced by widows would vary with their perception of the functional social support they received during the first year of bereavement. Statistically, the score on psychological distress experienced by widows would be negatively correlated with score on perceived functional social support both during the first three to six months of bereavement and during the second six months of bereavement.

The correlation between psychological distress as measured by the Goldberg General Health Questionnaire (GHQ) and the perceived functional social support as measured by the Total Functional subscale score on the Norbeck Social Support Questionnaire (NSSQ) is shown in Table 24. The GHQ and the Total Functional subscale scores on the NSSQ correlated positively ($r = .24$) at Interview I, contrary to the prediction. At Interview II, the GHQ and the Total Functional subscale scores correlated negatively ($r = -.19$), which was predicted.

TABLE 24

Correlations[a] Between Psychological Distress as Measured by GHQ and Perceived Functional Social Support as Measured by Total Functional Subscale on NSSQ During the First Year of Bereavement (N = 30)

Variables psychological distress and perceived functional social support	Correlation
Interview I	r = .24 (P = .11)
Interview II	r = -.19 (P = .16)

a Pearson product-moment correlation coefficient

Although the GHQ and the Total Functional subscale scores correlated negatively at Interview II, they were not statistically significant. Given that the level of significance was set at .05, these hypothesis concerning the inverse relationships with psychological distress and perceived functional social support during the first three to six months of bereavement and during the second six months of bereavement were rejected. It can be said that for this sample there was no statistically significant relationship between psychological distress and perceived functional social support during the first year of bereavement.

To explore the relationship between psychological distress and perceived functional social support further, the psychological distress groups and the Total Functional Subscale mean scores during the first year of bereavement were compared for women with various experiences of psychological distress (high-high, high-low, low-high, low-low). This analysis indicated that all the women (n = 26) except for those women experiencing high psychological distress throughout the first year of bereavement reported an increase in their perceived functional social support (see Table 25). Those women with high psychological distress (N = 4) reported a decrease in their perceived functional social support during the first year of bereavement. It may be that the women in this latter group perceived a decrease in their perceived social

TABLE 25

Total Functional Mean Subscale Scores for Psychological Distress Groups During the First Year of Bereavement (N=30)

Psychological distress groups		Total Functional subscale Scores Interview I	II
High High	4	246	233
High Low	11	248	253
Low High	1	109	201
Low Low	14	234	261

support network and this contributed to the decrease in their perceived functional social support during the first year of bereavement. It may also be that all women had difficulty in responding to the instrument's questions.

Analysis of the qualitative data of this investigation offers possible explanation of this finding. Two examples are presented.

> Mrs. C had an initial GHQ of 16 at Interview I which decreased slightly to 11 at Interview II.
>
> At Interview I she had no family here to have regular contact with. She felt very isolated, as she could communicate only with her young family and a couple of neighbour friends. She had not met any new friends. NSSQ at Interview I revealed 2 young children, 3 friends and 1 health care provider in her network. Because her children were so young, she felt she could not expect too much from them in terms of support.
>
> At Interview II, she was still missing the contact and support of her primary family who lived very far away. She was seeing only one neighbour who was not very supportive. "All she ever talks about are all the troubles that men can cause." She still had not made any new friends and found it difficult to get out to meet new people because of the responsibility of the children. NSSQ at Interview II revealed 3 friends, 3 family members, one of whom was her mother who was trying to keep more contact with Mrs. C but because of living so far away, found it very difficult and very expensive; Nevertheless, she reported that her network were very agreeable and supportive with her actions and thoughts. She felt she could ask her network for financial aid at any time.

Mrs. D had a GHQ of 10 at Interview I and 10 at Interview II.

At Interview I she was surrounded by her family and neighbour friends. She was not seeing her husband's family nor had she made any new friends. She was leaning very heavily on her friends from work who were very supportive to her. NSSQ at Interview I revealed 17 family members and 5 friends in her network. Both friends and family scored equally in affect, affirmation and aid.

At Interview II, she was seeing her work friends daily and her son had moved in with his family to live with her. She still was not seeing her husband's family nor had she made any new friends. Because of the extra family responsibilities, she was not getting out as much. NSSQ at Interview II revealed 12 family members, 2 friends and 2 neighbours in her network. The scores on both aid and affirmation had decreased from Interview I to Interview II. She was being troubled by many health problems also.

Both of these examples reflect the consistency between the responses on Widow Interview Guides I and II and the quantitative measures on the NSSQ. For both of these women, as with other women who experienced high psychological distress throughout the first year of bereavement, the narrative from the semi-structured interviews did seem to indicate that there was a decrease in the functional aspects (affect, affirmation and aid) of social support. As with all the women, the functional changes were very individualistic although for the sample in general, there appeared to be increase in the functional aspects of social support during the first year of bereavement.

Variables Other Than Perceived Social Support Affecting Psychological Distress

Psychological Distress and the Background and Personal Characteristics of the Women

To explore the relationship between psychological distress and various background and personal characteristics of the women such as: age, parent still living, attendance at religious services, length of marriage, children under 18, future work plans, perception of cause of death, length of time husband was ill, discussion of impending death with husband, experience previous with death, monthly income before death, monthly income after death and driving status, the chi-square statistic was used (with Yate's correction if necessary), with level of significance set at .05. The findings in this investigation suggest that there was no statistically significant relationship between psychological distress as measured by the Goldberg General Health Questionnaire and various background and personal characteristics of the women (some of which were dichotomized and others described by more than two categories).

It was found, however, upon subsequent analysis that living arrangements presented some interesting findings. For the women living alone, the mean GHQ score for psychological distress at Interview I was 4 while the mean GHQ score for the women living with others at Interview I was 7. This

suggests that the women living with others at the time of Interview I were more psychologically distressed than the women who were living alone in spite of the fact that those who lived with others had higher perceived social support network and perceived functional social support scores. At Interview II, six months later, both groups of women had comparable scores on psychological distress. Table 26 indicates selected background and personal characteristics of widows by living arrangements: those living alone and those living with others as well as their psychological distress scores for Interviews I and II. Those who were living alone had more post-secondary education than the group living with others. Women living alone were older. Both groups of women reported increases in their perceived social support network and perceived functional social support during the first year of bereavement.

An analysis of the women who reported high psychological distress scores throughout the first year of bereavement revealed concurrent stressors which may have been influencing their psychological distress. Feelings of vulnerability regarding buying a car and having house repairs done caused one woman to have difficulty with sleep (which has been addressed earlier as being associated with psychological distress in this investigation). This woman stated:

> I feel I am treated differently because I don't have a husband now and this makes me feel very vulnerable especially when I am making a major decision such as buying a car or having electrical work done in my home.

TABLE 26

Selected Background and Personal Characteristics of Widows by Living Arrangements: Those Living Alone and Those Living With Others

Variable		Living alone (n = 8)		Living with others (n = 22)
GHQ Score initially	M	4	M	7
GHQ Score six months later	M	3	M	2
Yearly income:				
Before death of husband		$25,329		$23,702
After death of husband		$15,161		$14,770
Age		60		53
Education				
Not finished high school		2		13
Finished high school		0		3
Post-secondary or university		6		6
Sudden death		4		11
Chronic illness		4		11
Working		3		7
Perceived social support network score				
Interview I	M	110	M	130
Interview II	M	117	M	135
Perceived functional social support score				
Interview I	M	207	M	246
Interview II	M	222	M	263

other women with high psychological distress throughout the first year of bereavement reported additional stressors such as a child ill, worry regarding her work union electing to go on strike, feelings of insecurity regarding her husband's estate and recurrent guilty feelings regarding her husband's illness and death.

Many of the women (47%) in this investigation experienced low psychological distress. The marital relationship with the spouse and the widow's educational level were critical factors influencing the widows' perception of the change in themselves since their husbands had died. Ultimately, this perception affected their psychological distress. One woman in this investigation paints a clear picture:

> My life has changed now that my husband has gone. There is no more drinking, no more abuse towards me and my children. There never was enough money for food or repairs. Now, there is peace, money to buy groceries and make repairs to the house. I don't have to worry about tomorrow.

However, for some of the women, making decisions alone without their husbands was often a source of anxiety because they repeatedly questioned whether they had made the right decision (e.g. to move, to sell the house, to go to work). Some of the women were fearful regarding personal safety and security and had nightmares about people breaking into their homes. For some of the women who were not accustomed to handling financial matters, the ordinary routine of paying bills monthly and making purchases presented difficulties.

That 70% of the women reported attending religious services at least once a week would suggest that organized religion is perhaps influencing the widow's outcome. Thirteen women of the sample listed a clergyman as a member of their social support network. Eleven of these women were found in the low psychological distress group (n = 14) throughout the first year of bereavement. It may be that religion was a comfort to those women and this in turn affected their psychological distress level. While religion seemed important to some, none of the women who reported high psychological distress throughout the first year of bereavement derived either comfort or support from religion or indicated a clergyman in the social support network. Two of these women stated that they were disillusioned with their religion and two stated that they had no religious beliefs. There was no statistically significant relationship found between psychological distress and attendance at religious services.

Seventeen women stated that they believed in some form of life after death. Some women offered the following comments about life after death:

> It is what keeps us going.
>
> There has to be a reason for what happens to us and to those we loved.
>
> There has to be a better place than here for peace and no suffering.
>
> I don't believe in what the church teaches us as life after death - there is some life but not in the same form.

> I believe that there must be a life after death as that is what we are taught and told from the time we were young.
>
> Life after death means to me that I will be going to heaven to be with my husband.

Although most women can expect to survive their husbands, the experience of having grieved for a spouse may tend to make a woman view death differently from the way in which her husband viewed it. In this investigation, many of the women stated that they believed that death was final, the end of life's experiences. One woman stated that:

> Death is final, like a flower which grows, dies, falls to the ground and rots.

For some of the women, death was perceived as the end of their husband's suffering and/or a release from responsibility. Some women expressed the following comments:

> Death has brought dignity to my husband. After many years of suffering, he is now at peace with himself. I would not want him back - I really lost my husband many years ago when he had a stroke.
>
> Death is a better place than here. We must all face it and accept it when it happens. I believe that my husband is in a better place than here.
>
> Death is not the end - it is perhaps the beginning of a new experience.

One of the most pervasive of all sentiments expressed explicitly by the widows in this investigation is the feeling that their new status was a drop in rank from the marital state. Many widows stated that they hated the word "widow". To them, widow is a harsh and resented word, a word that

comes from Sanskrit and means empty (Caine, 1974). One woman in this investigation stated:

> I never really realized how many widows there were until one day when I was in church. I looked around; all I saw were widows. I had become one of them even though I didn't want to be one and be a part of this group. I had joined the community of widows.

Many women expressed the need to be needed by someone. The women, especially those without children geographically close, found it difficult to find someone with whom to share their feelings and the burden of their grief.

At the end of the first year of bereavement, a few women were thinking about the possibility of remarriage in the future:

> ...I would like to remarry for companionship and financial security.

> ...I would like to think that someday I will meet someone and remarry. It is very hard to think that I will spend the rest of my life alone.

> ...I would like to remarry again but the chances will be slim: all that is available are rejects, alcoholics and men with problems. I really don't want to get involved with someone with any problems and yet I really don't want to spend the rest of my life alone.

For some women at the end of the first year of bereavement, there was a growing need and sense of determination to form a new self-identity. One woman explained during Interview II:

> I really want to become my own person-going back to school and getting involved with other people has really helped me gain self-confidence I never had. I never had the opportunity to think about myself before and now I am going to consider

> myself first. I feel better about myself now since I am thinking this way.

Some women were seeing personal growth as a result of their husband's death. They saw themselves as having increased confidence, a new sense of self, improved productivity at work, the ability to initiate new activities and a new independence. In an open-ended question asked at the end of Interview II (what do you find yourself thinking about these days), another woman responded:

> Becoming my own person is very important to me now. For so many years, I was someone's child, someone's wife, someone's mother; now I feel I have been half a person. I wonder who I really am. Can I become my own person who has a contribution to make to society. I watch others to rule out what I don't want for myself. I really am searching for something to make me my own person and now I have that opportunity to become a whole person.

In a retrospective view of the first year of bereavement, many of the women stated that loneliness was their most serious problem. Some of the women's comments regarding what loneliness meant to them were:

> ...fear of doing little things on my own such as locking up at night, deciding where to live, driving at night, making the right decision.
>
> ...learning to depend upon myself as there is no one else to turn to.
>
> ...having to make decisions on my own without the reassurance and the joint responsibility of my husband.
>
> ...finding enough activities to fill my days and nights - there is not enough for me to keep me busy.

Another woman talked of the feelings of disengagement she was experiencing and which were troubling her at the present time:

> ...the feelings of disengagement or remoteness when I am with others (i.e. not remembering places, names of people I have known for years or directions to go somewhere). After 5-10 minutes I will remember the exact details. Imagine starting out to go somewhere and not remembering where I was headed. It is scary - I feel on another plane or level.

One woman very vividly described her growth from loneliness over the first year as follows:

> ...Before, I felt like I was in a dory lost three miles out at sea not sure of what direction I was headed. I had no paddles and I was drifting in a storm. Now, I can see land; I have paddles and I have a bucket to bail myself out. Also if necessary, I feel that I can swim to land.

Important as friendships, both old and new, and continuing family relationships were in the lives of widows, they were not enough to dispel the single major problem for bereaved women: loneliness. They did not compensate for the loss of the husband. Friends and activities made loneliness easier to manage and accept, but did not diminish it.

While some of the women lived apart from their families, this was by no means synonymous with loneliness and social isolation. Many women who lived with family reported extreme loneliness. Some of the women living alone reported only mild incidents of loneliness. Nevertheless, loneliness in

c

some degree was a problem for most of the women. One woman indicated how much her marriage was meaning to her now:

> ...I really never knew what marriage was all about until my husband died. It really consisted of 99% companionship and the other 1% sex. You never really appreciate what you have or really think about it until it is gone from you.

The type of death and the way in which it is perceived may have an effect on psychological health. The present investigation found no difference in the psychological distress of widows whose husbands had died of sudden deaths versus chronic illness both at Interview I and II. When the illness was defined as chronic rather than sudden death, the time perspective of the woman was extended and when death came, it was more expected and therefore less of a shock to her. One woman states very clearly her initial reaction:

> I was shocked. I knew that it was going to happen but not so quickly. I felt very much alone and completely overwhelmed by all the decisions that had to be made.

It may be that middle-aged widows may have the same grief reaction for both sudden and chronic illness here in Newfoundland and that anticipatory grief plays no part in determining psychological distress during the first year of bereavement. Neugarten (1970) suggests that:

> ...it is more often the timing of the life event, not its occurrence, that constitutes the salient or problematic issue... Major stresses are caused by events that upset the sequence and rhythm of the life cycle. (p. 86)

It is not generally anticipated that spousal bereavement will occur before one is elderly and retired. This investigation found no significant difference in psychological distress in those women under 55 and over 55 years of age. However, all of the widows were experiencing what may be perceived as untimely bereavement and this may have contributed to the initial psychological distress experienced by the sample.

Psychological Distress and the Physical and Psychological Health Characteristics of the Women

To explore the relationship between psychological distress and various physical and psychological health characteristics of the women such as: health since husband died; professional help from physician; professional help from psychiatrist; taking medications since death of husband; feeling that it is difficult to do things; having difficulty with concentrating, making decisions working, activities of daily living, meeting people, eating, sleeping, drinking, smoking and maintaining weight, the chi-square statistic was used (with Yate's correction if necessary) with level of significance set at .05. The findings in this investigation indicate that there was a statistically significant relationship between difficulty with eating and psychological distress as measured by the GHQ at Interview I while at Interview II, professional help from a psychiatrist, difficulty concentrating and

difficulty with sleeping were significantly associated with psychological distress.

For further analysis, a forward multiple regression was conducted for each Interview, utilizing as the dependent variable the Goldberg General Health Questionnaire (GHQ) score which measures the construct psychological distress and as predictor variables selected characteristics of the sample as well as the total Network score and Total Functional score. The results of the analysis are shown in Table 27. For Interview I, three of the predictors entering the equation accounted together for 57% of the variance. Having difficulty with sleep accounted for 37% of the variance at Interview I whereas it accounted for 45% of the variance at Interview II. It has been stated earlier that many of the women reported difficulty with sleeping during the first year of bereavement. Fifty-seven percent of the women reported difficulty with sleeping during Interview I and 37% during Interview II. Also at Interview I the widow's perception of her health as just the same since her husband died accounted for 11.1% of the variance and seeing and talking with close friends accounted for 9.5% of the variance at Interview I. At Interview II, no variables other than difficulty with sleeping accounted for the variance. Neither Social Support Network or Functional Social Support accounted for an important part of the variance at either Interview I or II.

TABLE 27

Regression Analysis of Variables Contributing to Level of Psychological Distress as Measured by GHQ During the First Year of Bereavement (N = 30)

	Interview			
	I		II	
Variable	Standardized Beta	% Variance	Standardized Beta	% Variance
Difficulty with sleep	.60	36.5%	.67	45%
Health since husband died	-.36	11.1%		
See or talk with close friends	.34	9.5%		

To explore the relationship between psychological distress and the widow's perception of her health, a further analysis was attempted. A crosstabulation of psychological distress as measured by the GHQ with the widow's perception of her health during the first year of bereavement is displayed in Table 28. At Interview I, eight of the women who reported high psychological distress (GHQ 5-30) rated their health as worse; only 2 of 15 women reporting low psychological distress (GHQ 0-4) rated their health as worse. At Interview II, 2 of 4 women reporting high psychological distress rated their health as worse. One woman with a GHQ > 5 rated her health as better. Six women reporting low psychological distress rated their health as worse.

In addition to the GHQ scores, living arrangements were examined in relationship to the widows' perception of their health during the first year of bereavement. Selected physical and psychological health characteristics of those women living alone as well as those women living with others are displayed in Table 29. Six of the 8 women living alone rated their health since their husband had died as just the same during Interview I and 2 women rated their health as worse. Fourteen women living with others rated their health as just the same while 8 women rated their health as worse at Interview I. During Interview II, 2 of the women living alone rated their health as better since Interview I whereas 9 of the 22 women living with others rated their health as better. It appeared

TABLE 28

Crosstabulation of Psychological Distress as Measured by Goldberg General Health Questionnaire with the Widow's Perception of Her Health During the First Year of Bereavement (N = 30)

Psychological distress	Widow's perception of her health		
	Just the same	Worse	Better
Interview I			
GHQ 0-4	13	2	
GHQ 5-30	7	8	
Interview II			
GHQ 0-4	9	6	10
GHQ 5-30	2	2	1

TABLE 29

Frequency Distribution of Selected Physical and Psychological Health Characteristics of Widows by Current Living Arrangements: Those Living Alone and Those Living With Others

Variable	Living alone (n = 8)	Living with others (n = 22)
Health since husband died (Interview I)		
Just the same	6	14
Worse	2	8
Health between Interview I and Interview II		
Better	2	9
Just the same	3	8
Worse	3	5
Professional help from physician		
Yes	4	12
No	4	10

that the women living with others perceived their health as better than the women living alone.

Psychological Distress and the Social Characteristics of the Women

To explore the relationship between psychological distress and various social characteristics of the women such as: seeing or talking with close friends, seeing or talking with husband's friends, seeing or talking with family members, seeing or talking with members of husband's family, making new friends, feeling closer to certain people, seeing some people less frequently than before, turning to anyone in particular to discuss problems, the chi-square statistic was used (with Yate's correction if necessary) with level of significance set at .05.

At Interview I, making new friends was found to have a statistically negative significant relationship with psychological distress while at Interview II, having someone in particular to discuss any problems you might have, was found to have a statistically positive significant relationship with psychological distress. It was found in multiple regression that the predictor variable: seeing or talking with close friends, accounted for 9.5% of the variance with the major construct of psychological distress at Interview I (see Table 27).

Seven women reported at Interview I that they had made new friends. At Interview II, 9 women reported they had made new friends since the last interview. Of these friends, school or work associates were mentioned the most frequently. Five women had made attempts to form a new self-identity by returning to school and employment.

Interestingly, the women reported other widows as part of their network only during the first six months of bereavement. Nineteen women had talked with other widows. They mainly found that comparing and sharing experiences, receiving and giving information (e.g. about new laws regarding increase in spousal allowance for widows), getting reassurance and helping others had been very helpful to them. Several women had some very interesting comments:

> ...sharing experiences and feelings has been very helpful for me. Getting the reassurance that I am not alone and that others have gone through this experience and survived is very comforting.
>
> One woman who lost her husband 3 years ago has been very helpful in getting me out of the house and starting to think about the future.
>
> I have an older friend who is widowed for many years who I lean on and confide in. I have also a young friend who recently lost her husband a few months ago. Being able to help her through this experience has really helped me and has made me feel better and needed.

Six women had found this experience negative. They found recent widows too pre-occupied, some widows very negative and there

were some personal things that they would rather not share. One woman stated:

> ...the other widow I talked with was so depressed that I felt worse after talking with her. I really could have talked with someone who had survived the experience positively.

Some women indicated that they would have liked a group to share their problems and feelings with:

> I would have liked to have a group of women who have been widowed to talk about my feelings and share experiences.
>
> I only wish that I had found a group to seek advice from and reassurance on decisions. Also to know the feelings I was experiencing are not only my feelings but also of others who have gone through a similar experience.

Adult children also suffered grief at the loss of their father. A few women found that their children's grief reaction was so extreme that the role of "widow" with a right to mourn and be taken care of was set aside for the role of "mother" with a responsibility to protect her children. This created a considerable amount of stress and role strain for the women. A sense of family obligation caused these women to accept the role of mother first and widow second. One woman explained her situation:

> My adult son has become very unsettled in his own life. He gave up his job, moved in on me and forced me to sell the house to find larger accommodations for him and his family. I had to sell our family home and find him new housing just in order to keep the relationship open between my son and myself. All this has been very stressful and has made me make very hasty decisions too quickly.

Another woman stated that her children were constantly fighting and arguing and blaming her for not recognizing how ill their father had been and his death. Many women stated that their main concern for their children now was that the children would return to their religion and religious beliefs on a regular basis. The fact that the women had as a major concern that their children return to religion shows that religion is unusually important for this group as compared to other studies (Vachon et al., 1982). It might also be that this provides indirect evidence as to the trauma these children experienced with paternal death.

Family problems were usually shared with friends where support and practical assistance were given as an outgrowth of a more reciprocal relationship rather than out of a sense of obligation. The investigator suspects that the widow valued these network ties with friends and worked hard to maintain them.

In this investigation, a few women experienced social support from their families which was clearly interpreted as negative. One woman described very clearly her situation:

> My daughter is very over-protective. She checks on where I am going and what time I will be home. She waits up for me when I am out in the evening. She insists on keeping her father's belongings around the house. She will not even let me change things around the house, consider selling the house and moving into a smaller place. She wants the home to remain the same as when her father was alive. I find all this very stressful and very smothering.

A final concern of many widows was the lack of resources in the community to help the widowed. The needs of the widow (e.g. financial and legal advice, information as to available resources in the community) was mentioned by many of the women during this investigation. Some women made reference to the lack of some of these resources in the following comments:

> Widows are so very vulnerable.
>
> They are at everyone's beck and call. Agencies (insurance and financial) seem to be so insensitive in dealing with widows and everyone takes so long to get things (financial matters) settled.
>
> I wish insurance people would speak in more down to earth and simpler terms for a widow to understand.

Examples of Psychological Distress and Social Support During The First Year of Bereavement

This investigation has reviewed ways in which bereavement affects the widow during the first year of bereavement, examining the relationship between psychological distress experienced by the widow and the widow's characteristics, perceived social support network and perceived functional social support. Case studies are presented here in an attempt to present an integrated description of the experience of widows with various reported experiences of psychological distress as assessed at 3-6 months after the death of the spouse and 6 months later: high psychological distress, high psychological distress which decreased to low psychological

distress and low psychological distress. Some of the data has been changed to provide anonymity. The data that has been changed does not affect the essence of the case studies.

High Psychological Distress

Mrs. A. was a 56 year old middle-class widow who was quite attractive, worked as a part-time school teacher and was living alone. She had finished high school and had one year post-secondary education. Her husband of 32 years was 65 at the time of his death and had just retired six months previously. They had made many plans for retirement such as travelling, making renovations to their home and setting a large garden that spring. The husband had become very active in volunteer organizations which, because of the nature of the services, had created a very stressful situation for the husband. Mrs. A. felt that this involvement and the stress it had created for her husband was responsible for his death. His death occurred one evening just as they were watching the early evening news. He died immediately of a massive heart attack.

Mrs. A. lost a child several years ago in a tragic car accident. She stated that although the rest of the family (husband and 4 children) had apparently recovered from the loss, she was still grieving the loss of her child.

Mrs. A. attended religious services daily but stated that religion had not been supportive to her during this experience. She felt that death had "robbed" her of two important people in her life: her child who had been so very young and her husband who had been only 6 months into retirement. Mrs. A. and her husband had only talked about death casually: her husband would not make out a will and this had caused some problems in settling his estate.

During the first interview when asked how her health had been since her husband passed away, Mrs. A. replied that it had been only fair. Her blood pressure had elevated initially but now had stabilized. She stated that she had not slept well since her son had died and now was sleeping worse (i.e. short naps through the night and seeing the time hourly). She was eating poorly and not eating regular meals. She stated she was having difficulty making decisions such as whether to plant the flower garden and having some repairs done to the house. She missed her husband's reassurance.

She was seeing a close friend twice a week, her brother and children called her weekly and she stated that she and her sister-in-law had become very close. Her sister-in-law, who also had lost her husband and son, had been such a support to her. "I don't know what would happen to me if I were to lose her now." Her daughter came each weekend to spend time with her. Mrs. A. stated that she was not seeing couple friends as frequently as before, as most activities were couple-oriented and she felt that they would feel uncomfortable with her around. She said she felt angry about this because when she saw other couples together making plans and talking about their children and grandchildren, she then realized that she and her husband would not have the opportunity to do this.

When Mrs. A. was asked during the first interview what she was thinking about these days, she responded that she was worried about what was going to happen to her. She felt odd: "I don't fit into my children's lives nor into my couple-friends' lives". Small routines that she and her husband had had were difficult to break. She felt his presence very strongly in the evening when she went to bed and around the house when she was alone. She stated:

> ...it is very hard to learn to live alone. Others forget that you are there (friends, neighbours) and forget to visit or call.

> If I did not have my job to get out every day, I would find myself very isolated.

Mrs. A. was also learning to drive in order to become more independent.

GHQ score - 8

Perceived Social Support Network score - 71

Perceived Functional Social Support score - 163

During the second interview, Mrs. A. stated that having to make decisions on her own without the reassurance and joint responsibility of her husband had been her most serious problem since her husband had died. She said that she felt she was treated differently because she did not have a husband. This made her feel very vulnerable when it came to making a decision such as buying a car or having major renovations done to her home. Not having meals at regular times and having to do so many things that she never did before such as mowing the lawn, were the greatest changes she was experiencing in her daily life since her husband passed away. There wasn't anything she felt she had to do without because she could not afford it. Talking with other widows, especially her sister-in-law, had been helpful as she felt it was sharing information on how to survive. She stated that "getting my license to drive the car is the decision I feel was an especially wise one since my husband passed away." It gave her a sense of accomplishment as well as independence. Mrs. A. felt the loss of couple friends they used to socialize with together. She felt that she had joined a "community of widows". Long, lonely evenings and music both she and her husband had enjoyed together brought painful memories. Mrs. A. felt numb regarding her religious feelings ("My feelings are numb when I am in church and when I think about my religious beliefs"). She suggested keeping busy and keeping your mind occupied as advice to others who may be in the same circumstances.

Mrs. A. perceived that her health was fair since the last interview. She had been to see her physician regarding her insomnia which had gotten worse. She was not taking any medication but eliminating coffee from her evening meal as a step towards improving her insomnia. As in Interview I, she was still having difficulty with making decisions and activities of daily living such as cooking and cleaning.

She was still seeing her sister-in-law daily, talking with her children daily, her brother monthly. She still felt closer to her sister-in-law since her husband had died and turned to her to discuss any problems she might have. She felt very fortunate to have her job and the opportunity to get out and work with children as they distracted her and helped her forget about herself and her problems. She stated that she is not looking forward or thinking about the future. "My husband and I did that before and then he died before he could enjoy the things he had planned."

GHQ score - 9

Perceived Social Support Network score - 92

Perceived Functional Social Support score - 245

Mrs. A. demonstrates several of the problems encountered during the first year of bereavement: the loneliness; the difficulty with making decisions, activities of daily living and sleeping; feelings of vulnerability and social isolation. Living alone and having some post-secondary education to help in gaining employment gave her the opportunity to get out of her home environment each day to associate with others. The investigator suspects that the difficulty with sleeping contributed to her perception of her health as fair and to the overall high psychological distress score over the first year of bereavement. It can be seen that even though she was experiencing high psychological distress, her perceived social support network and perceived social support increased during the first year of bereavement. Although Mrs. A. can be seen as having experienced a major change in

her relationship with couple-friends, she perceived her significant other network increasing and the support they gave her as increasing also. She stated a reluctance at having to join a "community of widows". Again, the investigator suspects that this was associated with difficulty in accepting one's changed status which contributed to her psychological distress.

High-Low Psychological Distress

Mrs. B. followed the most typical pattern of psychological distress during the first year of bereavement. The problems she experienced and the resolution of her grief followed the pattern of 37% of women in this investigation.

Mrs. B. was a 60 year old middle-class widow who had been married to her husband for 43 years. She had finished Grade XII, married as a war bride and had never pursued any career. She has two sons: one living with her and one son who was living with his family in the same neighbourhood. Her husband was 67 at the time of his death and had been retired only one year. Mrs. B. had not been born here in Newfoundland but had come here from England as a war bride. She only had one sister who lived elsewhere and they were not close. She attended religious services about once a week. Her husband had died very suddenly of a myocardial infarction. She had sensed that he was unwell, but couldn't persuade him to seek professional help. She also sensed earlier that year that something dreadful was going to happen. Her husband had starting encouraging her to take over some financial matters concerning the house about six months previous to his death. Mrs. B. and her husband had casually talked about death and about what arrangements they would have liked for one another. The son who was living with her travelled frequently.

Mrs. B. was seeing a widow neighbour up the street three to four times a week; her son called her daily; and she had a working friend who was also a widow, with whom she

went out with once a week. She found that married couple-friends had ceased calling and, in fact, had called only once since the funeral. She stated she felt she only had herself to rely on for any difficulties she might encounter.

Mrs. B. had had a stroke about nine years previously and had completely recovered. During the first interview, she stated that she felt her health was good since her husband had died. She had not taken any tranquillizers or sleeping pills although she was experiencing a lot of difficulty with sleeping. She was sleeping 3-4 hours per night. She couldn't sleep in the day nor did she try to take any rest periods. She found spending Sundays alone very difficult. She stated that she found she was smoking more now that her husband had died.

When asked during the first interview what she was thinking about these days, she expressed a lot of angry feelings such as: "Don't expect anything from anyone, don't expect people to keep calling, don't expect people to keep interested in you, don't expect anyone to be concerned about you after the funeral". She was very upset that her husband's brother had not called or written since he heard about her husband's death. She and her husband's brother had been very close.

GHQ score - 8

Perceived Social Support Network score - 41

Perceived Functional Social Support score - 101

During the second interview, Mrs. B. said that loneliness and fear of "little things" (e.g. concerning the house, where to live) had been her most serious problem since her husband had died. She had sold her family home and had moved out of the neighbourhood where she had lived all her married life into an apartment complex. Learning to live without her husband and relying on herself was the greatest change she had experienced in her daily life. There wasn't anything that she felt she had to do without because she couldn't afford it. She felt that talking with other widows was very

helpful, especially those women who had been widows for many years. She found new widows too pre-occupied with their own problems to be that helpful.

Mrs. B. stated that she regretted moving away from a familiar neighbourhood where she had lived all her married life and was comfortable and knew everyone. She was glad, however, that she had sold her home as it was getting run down and needed many repairs. Her son was away so much and when he was at home she hated to bother him with the repairs. She felt that letting go of the responsibility of the upkeep of the home relieved her of the stress she felt during the first six months of bereavement. She felt that she was financially more secure now than she ever had been. Talking with her sons and grandchildren about her husband during happy times brought back painful memories. Her advice to others in the same circumstances was "to get on with your life - depend upon yourself to get yourself going, not on others". Mrs. B. felt that she had grown closer to her religion and she was attending church on a more regular basis.

Mrs. B. perceived her health to be just the same since the first interview. She was still only sleeping 3 hours per night and found she was very tired. Cooking for herself and making herself get things accomplished were also stated as difficult. She noted a decrease in her smoking and had gained 2-3 pounds.

She was still seeing her widow neighbour-friend and widow working-friend weekly and was talking with her daughter-in-law daily (her other son had gone away to graduate school for further study). She was also seeing her sister-in-law and brother-in-law weekly during which they went out for an activity. She stated she felt closer to her friends now since her husband had died and was turning to them to discuss any problems she might have. Mrs. B. explained that she found weekends especially Sunday the hardest to face as the day was so very long. "Everyone is busy with their families and

no one has time for you. You must force yourself to get out and make new friends or keep in contact with old friends and not wait for them to call you."

GHQ score - 2

Perceived Social Support Network score - 59

Perceived Functional Social Support score - 171

Mrs. B. typifies many of the problems women confront in adjusting to widowhood. The loneliness, the difficulty with decision-making, difficulty with sleeping and increased smoking are problems common to many of the widows. Although she perceived her network as withdrawn during the first interview, these network members still stayed with her during the first year of bereavement. Perhaps because of her age, her immediate friendship network consisted of widows. It may have been that Mrs. B. during the first interview was still experiencing the initial reaction of grieving, the anger, when she referred to her network. Her perceptions of her social support network and functional social support increased over the first year of bereavement. Difficulty with sleeping did not improve during the first year although psychological distress did decrease. Perhaps selling the house which may have contributed to her psychological distress initially, relieved her of the stress of managing a home. Forcing herself to get out and keep contact with others may have given her a sense of independence and being needed.

Low Psychological Distress

For about 47% of the women in this investigation the adjustment into widowhood was not perceived as very difficult. Some women were relieved when their husbands died (e.g. because of husband's chronic illness over 6-7 years or because he had been abusive). For other women, there was an acceptance of what the situation and circumstances presented. Mrs. C. presents a picture of this group.

Mrs. C. was a 50 year old woman who lived with her niece. She had completed two years post-secondary education and presently held a professional position with a local company. For many years, Mrs. C. had supported her primary family financially after her father had become ill and died. As a result, although she and her husband had gone out together for many years, she was only married to him for twelve years. He was 53 at the time of his death which was caused by cancer of the stomach. He had been ill for over one year although he was actively employed at the time of his death. Mrs. C. attended religious services several times a week, was actively involved in church activities and was very strong in her religious beliefs. She stated she was happy when she knew her husband was gone as it meant "his suffering was over - he died with a smile on his face. I knew then that he was with others he knew and loved."

About 10 weeks prior to her husband's death, Mrs. C. sensed that she should learn to drive the car as he seemed to be failing fast and he was having difficulty sitting behind the wheel of the car. She took driving lessons, acquired her driver's licence and drove the car at night for the first time when she was called to the hospital to her husband's death bed. She stated that she was pleased now that she had learned to drive as it meant that she was free to come and go as she pleased and that she didn't have to depend on anyone.

Mrs. C. stated her health was just the same since her husband died. She has her blood pressure monitored monthly as she has a history of hypertension. She had taken tranquillizers twice since her husband's death - both taken immediately following her husband's death. They were helpful at the time but she didn't want to continue taking them. She expressed no difficulty with sleeping. She had been trying to lose weight through Weight Watchers as she had become very overweight during her husband's illness (> 200 pounds).

Mrs. C. had many friends. She saw a working associate daily, mother weekly, sister and sister-in-law weekly and her niece daily. She found that she had grown closer to her friends at work. She stated that her brother-in-law had been very helpful at the time of her husband's death. "He guided over me and watched that I did not overdo it or become too tired."

When asked during the first interview what she was thinking about these days, she responded that she was too busy to think. She had joined volunteer groups at church and was keeping herself busy. She stated:

> ...one must move on with their life. I am too independent to stop living. I have no regrets. My husband and I had a very happy marriage and when it was time for him to go, I let him go and was happy for him. I do not feel that he has left me. I feel that he has moved on and someday I will join him.

Mrs. C. stated that she realized that she might have 20-25 years ahead of her and she didn't want to spend this time by herself. She expressed the wish for companionship for the years ahead.

GHQ score - 0

Perceived Social Support Network score - 247

Perceived Functional Social Support score - 499

During the second interview, Mrs. C. explained that worrying about her financial security was her most serious problem since her husband had died. Her involvement with church activities and the responsibility for leadership in these activities was perceived as the greatest change in her daily life. There was nothing that she felt she had to do without because she couldn't afford it and she felt talking with other women who had lost their husbands very helpful. She found that by being helpful to others has helped her keep busy, active and happy. The major change for her during the first year of bereavement was changing jobs because of incompatibility with her employer. She was much happier in her new position

as it was less stressful. Music and songs that she and her husband enjoyed together brought back painful memories although she continued to play the music often. She had to have her dog put asleep during the interval between the first and second interview. This made her feel worse than when her husband died as she felt that she was deliberately causing his death.

Mrs. C. perceived her health as fair since the first interview. She explained that when she initiated changing her employment position, it caused her anxiety and her blood pressure elevated. After she accepted her new position, she felt much better and her blood pressure is slowly decreasing to normal. She stated that she found housework difficult to face although she shared this with her niece. Because her niece was in school at odd hours, she found cooking meals for herself difficult. Also, she was so active outside the home that little time was spent there.

Mrs. C. was still keeping contact with her friends daily. She continued to see her mother and sister-in-law weekly, her niece daily. She felt closer to her friends since her husband had died and depended on them to discuss any problems she might have. She stated at the end of the second interview that she was living one day at a time and that helping others has helped her.

GHQ score - 0

Perceived Social Support Network score - 245

Perceived Functional Social Support score - 414

It is evident that Mrs. C. was quite prepared for her husband's death and was already used to assuming responsibility. There were some difficulties (i.e. disappointment at not having more years together married) but one gets the sense that this woman gained control over her life and initiated changes for herself early in bereavement. She also tapped resources around her for support and with the strength of

these resources was able to make changes in her life and initiate new interests for herself.

This section has illustrated three distinct responses of psychological distress during the first year of bereavement through an examination of the characteristics of the widow, perceived social support network and perceived functional social support. High psychological distress was seen to be associated with difficulty with sleeping, changing relationships with couple friends, resentment of the widow role, feelings of loneliness and vulnerability. The most typical response of psychological distress in bereavement was high psychological distress initially which decreased to low psychological distress. This response was associated with initial reactions of grieving, difficulty with sleeping and decision-making and making changes to adjust to a new lifestyle. Low psychological distress was associated with initial reactions of grieving, a sense of relief with the husband's death and/or a previous sense of independence within the marriage. Some of the women with low psychological distress utilized their resources and network to make changes or make choices in their lives.

Summary

The findings of this investigation were that the initial period of bereavement was associated with significant psychological distress in the majority of women. For most of these women, this psychological distress gradually decreased. However, a significant minority (17%) continued to report marked

psychological distress at the end of the first year of bereavement.

Three groups of women were identified at the end of the first year of bereavement: those whose scores on the Goldberg General Health Questionnaire were high, indicating high psychological distress throughout the first year of bereavement (n = 4), those whose scores on the Goldberg General Health Questionnaire were low, indicating low psychological distress throughout the first year of bereavement (n = 14) and those whose scores on the Goldberg General Health Questionnaire decreased from high to low, indicating high psychological distress initially which decreased to low psychological distress by the end of the first year of bereavement (n = 11).

Many of the responses on the Widow Interview Guides (I and II) complemented the responses on the Goldberg General Health Questionnaire (GHQ) and the Norbeck Social Support Questionnaire (NSSQ). Many women in this investigation reported difficulty with sleeping and, for some of the women, this continued throughout the first year of bereavement. Using the dependent variable psychological distress in a regressional analysis that included the two components of social support (Social Support Network and Functional Social Support) and selected characteristics of the sample, having difficulty with sleeping accounted for 37% of the variance at six months of bereavement and 45% of the variance by the end of the first year of bereavement.

Nine hypotheses were tested in this investigation. Seven hypotheses were rejected because they were not statistically significant. No statistically significant relationships were found at either six months or 12 months into bereavement between psychological distress and perceived social support network and perceived functional social support. A significant positive relationship was between perceived social support network and perceived functional social support during the first year of bereavement. The women in the sample stated that loneliness was their most serious problem. They identified family and friends as their main sources of social support. No relationship was established between age of widow or type of death of husband with psychological distress. Concurrent stressors such as family conflicts, difficulty with role of mother versus widow and social support as a negative situation were reported by with women experiencing psychological distress. Women living with others reported higher psychological distress initially than women living alone.

CHAPTER V

DISCUSSION

The two purposes of this investigation were to describe a sample of middle-aged widows living in Newfoundland and to determine the nature of a relationship between psychological distress and social support during the first year of bereavement.

The conceptual basis for the investigation was an adaptation of Kahn and Antonucci's (1980) model of social support (see Figure 2, p. 45). In the model, the widow's characteristics were depicted as influencing the requirements for social support, the perceived social support network and the perceived functional social support, and consequently the widow's outcome, the level of psychological distress during the first year of bereavement.

Quantitative data were obtained on the standardized instruments while qualitative data were obtained on the author-constructed interview guides during both interviews. The qualitative responses complemented the responses on the NSSQ and GHQ providing a comprehensive view of the first year of bereavement as well as further explanation of some of the quantitative results.

Accordingly, the results are discussed in relationship to the purposes and the conceptual framework for the investigation. The specific focus of the discussion is: the nature of the relationships between psychological distress and social support.

Relationships Between Psychological Distress and Social support

Prior to discussing the relationships between psychological distress and social support, the scores on these variables are discussed in comparison to results of other studies. Then, the results of hypotheses testing are discussed. To facilitate the latter presentation, the direction of relationships among psychological distress and social support in the literature and in the investigation is shown in Table 30.

From analysis of the widow scores on the Goldberg General Health Questionnaire for psychological distress at two points in time during the first year of bereavement, the widow may be characterized according to three distress responses that emerged: widows who never experienced high psychological distress (47%); widows who initially experienced high psychological distress but gradually returned to normal levels (37%); and widows who continued to have marked psychological distress levels even at the end of the first year of bereavement (13%). Only one woman had low psychological distress at Interview I and high psychological distress at the end of the first year of bereavement. Fifty percent of the women reported low psychological distress (GHQ scores) at Interview I; this increased to 83% by the end of the first year of bereavement.

TABLE 30

Direction of Relationships Among Psychological Distress and Social Support in the Literature and in the Investigation

Variable	Direction in Literature		Direction in Investigation	
	Interview I	Interview II	Interview I	Interview II
Psychological distress (Source: Clayton, 1973; Vachon, 1979)	+		+	
Social support network (Source: Schaefer, Coyne & Lazarus, 1981; Vachon et al., 1982)	-		+*	
Functional social support (Source: Schaefer, Coyne & Lazarus, 1981; Vachon et al., 1982)	-		+*	
Social support network and functional social support (Source: Schaefer, Coyne & Lazarus, 1981)	+	+	+*	+*
Psychological distress and social support network (Source: Berkman Syme, 1979)	-	-	+	-
Psychological distress and functional social support (Source: Andrews et al., 1979; Vachon, 1979)	-	-	+	-

* $p < .01$

Vachon (1979) found 26% of women remained highly distressed throughout the first two years of bereavement and 30% of women remained in low distress. It appears in this investigation a greater proportion of women experienced low psychological distress throughout the first year of bereavement than in the Vachon study. Perhaps for some of the Newfoundland women, the event of losing a spouse may not have been as stressful as for the women living in Toronto.

The nature of the sample in this investigation revealed that the women demonstrated striking differences than women in other studies of bereavement. Demographic data collected on the sample indicated that 24 women (80%) had family income below the poverty level ($19,000) after the death of their husbands. According to a recent National Council on Welfare report, two out of three Canadian widows live below the poverty line (Vachon and Rogers, 1984).

However, the income data may indicate more financial hardship than is the case for most widows in this sample. The traditional custom and the national statistics on the percentage of homeowners in Newfoundland must be taken into account. Although the question of home ownership was not directly addressed, many women in the sample stated that they did not have many financial concerns because they had no mortgage payments and they owned their own homes. Only 6 women stated that they had financial worries and that there were things that they had to do without because they could

not afford them. Some of these things were: large expenses such as major house repairs and replacing appliances within the home. These six women also missed the security of having a weekly income coming into the home.

The attachment the women had to their homes was evident in the pride they took in keeping their homes neat and tidy, actually shining in appearance both inside and outside. Also, the women made many comments regarding how important it was to them to be living in the home that either their husband had built or had made major renovations to make the house a home for them. The home was referred to many times as the center of their lives. The investigator suggests that many of these women derived comfort from living in their homes and from the memories of their lives together in the home with their husbands. The results suggest this as only two women moved and sold their homes. This was because of the responsibility of the upkeep of the home. One of these women stated that she regretted making this decision.

In Canada, among women aged 15 and older, a fifth have completed or attended high school; and, of the remainder, a fifth had a post-secondary certificate or diploma or university degree (Statistics Canada, 1985). When one looks at the present investigation of middle-aged widows, it is apparent that their levels of educational attainment are higher than in national statistical reports. In this investigation 15 (50%) of the women had finished high school. Twelve women had some

post-secondary education and 10 women were working either full-time or part-time. Brock (1984) suggested that well-educated women with extended work experience were more in touch with the mainstream culture. They had a greater array of interests and avocations. They were better prepared in non-material ways for living as single persons. They looked ahead and planned more for the future and exhibited more control over their lives. They got more involved in the community and were more physically and socially active in later years. Brock suggested that these involvements promoted and sustained physical and mental health. In this investigation, there appeared to be no difference in psychological distress or perceptions of social support between women of different educational status. It did appear to this investigator that women with more education tended to be more involved in community affairs and in desiring to seek some employment after the deaths of their husbands.

With regard to religion, the investigator suspects that religion was playing a major role in the adjustment to widowhood. The fact that all the women identified a religion to which they belonged and that 70% of the women reported attending religious services at least once a week would confirm this. Also, the results that 37-40% of the respondents listed a clergyman as a source of support might suggest that most of these women were being influenced by their religious beliefs and practices during the first year of bereavement.

While it is not generally anticipated that spousal bereavement will occur before one is elderly and retired, the women in this investigation experienced what might be perceived as untimely bereavement. All of the women appeared to experience the various phases in the grieving process as described by Clayton et al. (1968), Click et al. (1974) and Maddison & Viola (1968). Most of the women displayed little bitterness to this event and the investigator suggests that perhaps the cultural environment which might be considered hardier and accepting of life events, might be influencing the response to bereavement with these women. If this is so, the investigator might then question what does it mean to the women's self-confidence and self-esteem to experience widowhood as an untimely experience.

The location of the investigation was the metropolitan area which consisted of the area of St. John's proper and some of the surrounding communities which are termed the urban fringe. Over half of the women in the sample were born in the rural communities of Newfoundland and had moved into the city or urban fringe early in their single or married lives. Historically, rural Newfoundland communities have been small in size and as a result have had closely knit community relationships. This may have affected the results of the study as the women from the urban area could have brought the rural customs plus their family and friendship ties into the city with them or it may have been that the

urban fringe may be close knit in family and friendship ties and this affected their response to bereavement.

Historically also the harsh physical environment has had significant impact on the lifestyles and the part that death and bereavement have played in the lives of many of the people in this province. The Ocean Ranger was an example where many people in this province were affected by the number of Newfoundlanders who were lost at sea. The support that was generated within the province by those who were directly and indirectly affected was remarkable. It may be that the combination of the influence of social environment and the expectations of living in a harsh physical environment were influencing the women in this investigation.

In summary, the women in the sample presented a perspective on how women in the St. John's area of Newfoundland responded to bereavement. The traditional custom and national statistics on homeownership showed that many women in the sample owned their own homes and stated that they had no financial worries. The women in the sample show more post-secondary education than the Canadian norm. Church attendance and support from clergy were identified as playing a major role during the first year of bereavement. Many of the rural customs such as strong family bonds and friendship ties were found in the urban and urban fringe sample. A greater proportion of women in this investigation reported lower psychological distress

scores throughout the first year of bereavement than found in other studies.

On the basis of what seems to be local custom, the investigator then suggests that the social environment here in Newfoundland provides some expectation for the widow to follow which would create a sense of security for the widow and the family on the appropriateness of behaviour to exhibit during widowhood. One might then question whether these expectations create positive or negative stress for the widow. These are questions which might be explored in another research study.

As Clayton (1973) and Vachon (1979) found enduring psychological distress during the first year of bereavement, the hypothesis that psychological distress would be positively correlated from early in bereavement to the end of the first year of bereavement was tested on the sample. The finding regarding the hypothesis on psychological distress during the first year of bereavement was not supported in this investigation. Psychological distress during the first three to six months was positively correlated with psychological distress during the second six months of bereavement. Although there was a positive correlation, it was not statistically significant.

The cumulative nature of stressful life events has been studied by Holmes and Rahe (1967). In the present investigation, the women experiencing high psychological distress during the

first year of bereavement had other concurrent stressors related to finances, health problems and family problems, in addition to the crisis at hand. This was also reported by Vachon (1979). The crisis of bereavement caused or complicated other difficulties, a situation which certainly can increase psychological distress. Vachon (1984) suggests that it might be interesting to speculate whether there is a causal relationship between these stressors or whether personality factors may have been operating to aggravate a stressful situation in response to the crisis of bereavement.

An interesting finding in this investigation was that widows living alone had lower psychological distress during the first six months of bereavement than those widows living with others. The psychological distress for both groups of widows at the end of the first year of bereavement was the same. This finding is interesting when one looks at Vachon's study (1984) which suggested that women diagnosed as having breast cancer, who were living alone or who were widowed, were very likely to die earlier than women living with others. In another investigation, it might be interesting to look at the longterm effects of widowhood here in Newfoundland.

Although the present sample reported a slight increase in the mean score on perceived social support network on the Norbeck Social Support Questionnaire during the first year of bereavement, the analysis of the widow's scores on the Total Network subscale revealed that 17 women (57%) actively

reported a decrease in their perceived social support network. All of the women in this investigation reported family members as part of their network. The finding that the majority of women reported network members as those they had known 5 years or more would indicate that these women had fairly stable relationships. It may also be that because a higher proportion of Newfoundlanders (80% of the sample were born and raised in Newfoundland) than those in Toronto, Boston and/or Chicago grew up in the local area, married and are still living here, they have been able to retain more contacts with siblings, other extended kin and friends over the years. Martin Matthews (1982) also found stability in relationships in her sample of women in Guelph, Canada.

In response to the question eliciting significant people in your life, most of the women overwhelmingly reported each and every member of their family. Friends were also reported frequently as significant people. Perhaps the nature of the cultural environment which could be perceived as family oriented accounted for this overwhelming response. Most Newfoundlanders have little social or geographical mobility and as a result rarely experience the kind of social isolation or alienation that can occur in large industrial centers. Family bonds are strong and these ties were reported by the women as giving a meaning to their lives. Although the scores on the frequency of contact remained relatively stable, some of the women reported that as they returned to

employment, they did not have the opportunity to see family members and friends as frequently as before.

Although the sample reported a slight increase in the mean score on perceived functional social support on the Norbeck Social Support Questionnaire during the first year of bereavement, analysis of the widows' scores revealed that only 16 women (53%) reported an increase while 13 women (43%) reported a decrease in their perception of functional social support during the first year of bereavement. The mean scores on the Total Network subscale and Total Functional subscale are comparable to those on the Kirschling (1984) and Norbeck (1982) studies.

Although the mean scores on the Total Network subscale and the Total Functional subscale revealed an increase during the first year of bereavement, one might look cautiously at these scores as the analysis of the widows' scores indicated that there was considerable shifting of the network during the first year of bereavement. Even though there was a shifting of the network, a statistically significant correlation was found between perceived social support network and perceived functional social support.

On the Total Functional subscale of the NSSQ, among affirmation, aid and affect, the latter was the type of support most frequently provided to the widow. Specifically, the women were appreciative that their network demonstrated more love and respect (i.e. affect) toward them. However,

when the particular questions used to measure affect in this investigation were presented, several women did not discriminate among the network members. For example, a family member and a neighbour would earn an identical score for making a widow feel liked or loved. This finding was also reported by Trewin-Nugent (1985) who found that family caregivers of terminal cancer patients did not discriminate between network members for the affect type of support.

One explanation for this lack of discrimination may be associated with the difficulty that some of the women experienced with the actual questions. Specifically, when the investigator asked, "How much does this person make you feel respected or admired?", the women frequently hesitated and stated that part of their difficulty with the questions was that they had never really thought about the persons along those dimensions. It would seem that the women associated the perceived functional social support type, affect, with an expression of caring/concern rather than admiration and respect. Trewin-Nugent (1985) suggests that caring/concern may be a more meaningful description of affect with this population.

That widows perceived support from others for their actions and thoughts is evident in that this item of affirmation received the second highest mean score of the three items of functional social support. Affirmation increased more than affect and aid during the first year of bereavement. The investigator concludes that the widows must have been receiving

reinforcement by sharing confidences and by perceiving that those around them were agreeing and supporting their actions and thoughts.

Aid was reported as the type of functional social support that was relatively less available to widows. This finding is consistent with Kirschling (1984) and Norbeck (1982). In the present investigation, the researcher suspects that one factor that may account for this low reporting is that the measurement of aid was not comprehensive enough to include components of aid which may be relevant to this population, for example, time or information. Kahn and Antonucci (1980) defined aid as "those transactions in which direct aid or assistance is given including things, money, information, time and entitlements" (p. 268). Although things, money and services were elements of aid which were measured in this investigation, no measurement of time or information was included.

For many widows, the item "if you were a patient" created an occasion for discussion of concerns and worries. The vulnerability of being alone and being a widow was expressed many times by the widow at this point. Some widows made comments such as:

> ...don't expect anything from anyone. Don't expect people to keep calling. Don't expect people to keep interested in you.
>
> My family (sons and daughters) have their own families. I can't expect them

> to take care of me if I take ill nor do I want to burden them with my problems.
>
> I worry every day that I might take sick and die and then who would take care of my young son. It is more important than ever for me to take care of myself.

The findings regarding the hypothesized negative relationship of each component of social support (perceived social support network and functional social support) from early in bereavement to the end of the first year were not supported in this investigation. As Schaefer, Coyne & Lazarus (1981) and Vachon et al. (1982) found negative changes occurring in social support over time, the investigator assumed that the sample would perceive a negative change in social support network and functional social support during the first year of bereavement. As the correlations of the these hypotheses were in the opposite direction than those hypothesized and statistically significant, alternate hypotheses regarding these components of social support were accepted. The sample did not perceive a decrease but an increase in social support network and functional social support during the first year of bereavement. It may have been that as time passed and things went well for the women, they felt better supported and perceived an increase in their social support.

The findings in this investigation support the hypothesized positive relationship of perceived social support network to perceived functional social support (i.e. as the perception of the network increased, so did the perception of functional

social support). This finding emphasizes the strong connection between the two variables. Indeed, this finding suggests they are not separate, but very closely associated entities. Schaefer, Coyne & Lazarus (1981) also support this finding. The literature however, raises questions and has a note of caution in studying the relationship between the two variables.

Although no one would deny that social networks are important in an individual's life, how they operate and whom they affect in what way are still largely unknown. How does one know for any given individual what a good social network is? Does the supportiveness of any particular network vary with the specific situation or needs of the individual? Walker et al. (1977) found the effectiveness of a network in providing support to widows depended only partly on network structure. Also important was the type of crisis and its phase, as well as the widow's ability to take advantage of the resources of her network.

Attempts by the network to provide social support may some times be counter-productive (Silver and Wortman, 1980; DiMatteo and Hayes, 1981). For instance, network members may encourage false hopes or maladaptive denial. Some attempts at support may threaten the widow's freedom to make her own decisions or interfere with the development of coping mechanisms. Although meant well, help can lead to dependence and passivity. Also, the very label "support" often implies that people are incapable of solving their own problems. Well intentioned

statements such as "It's not as bad as it seems" can hinder supportive communication.

On the basis of the literature review, the investigator inferred that psychological distress would be negatively correlated both with social support network (Berkman & Syme, 1979) and with functional social support (Andrews, et al., 1978; Vachon, 1979). In this investigation, the findings did not support the hypothesized relationship of psychological distress to social support network. Psychological distress was positively correlated with social support network during the first three to six months of bereavement and negatively correlated during the second six months of bereavement. Although there was a negative correlation during the second six months of bereavement, it was not statistically significant.

These results indicate that the widow's perceived social support network may not have been a major factor during the first six months of bereavement and yet during the second six months may have become important enough to the widow to affect her psychological distress. Perhaps a more appropriate hypothesis for this sample might have been: as time passes during the first year of bereavement, psychological distress will become more negatively correlated with perceived social support network than during the first six months of bereavement.

During Interview I, both women with high and low psychological distress reported high scores on perceived

social support network. This was also the case during Interview II. Also, low scores on perceived social support network were reported by women who had low psychological distress both at Interview I and II. The women with initial high psychological distress whose scores decreased to low during the first year of bereavement had lower Total Network Subscale scores in Interview II than in Interview I. It may well be that some of these women were reporting that some members of their network had withdrawn or that these women were being selective regarding who they regarded as being supportive to them by the end of the first year of bereavement. A look at the qualitative responses does not reveal any information regarding shifting of the network and/or its effect on psychological distress.

As with the social support network, the findings did not support the hypothesized negative relationship of psychological distress to functional social support in this investigation. Psychological distress was positively correlated with functional social support during the first three to six months of bereavement and negatively correlated during the second six months of bereavement. Although there was a negative correlation during the second six months of bereavement, it was not statistically significant.

Again, the results indicate that the widow's perceived functional social support may not have been a major concern during the first six months and yet during the second six

months may have become important enough to the widow to affect her psychological distress. Perhaps a more appropriate hypothesis for this sample might have been: as time passes during the first year of bereavement, psychological distress will become more negatively correlated with perceived functional social support than during the first six months of bereavement.

The women with high and low psychological distress reported high scores on functional social support during both Interview I and II. Some women with low psychological distress reported low functional social support. As some women reported additional family or friends as supportive, so did they report an increase in their perceived functional social support. As reported earlier, strength of the family bonds and the friendship ties were very evident in this investigation. Also, the availability of the network members may have given the widow the sense of security and reassurance of herself as a person.

The women who reported high psychological distress throughout the first year of bereavement decreased their Total Functional Subscale scores from Interview I to Interview II. It may be that some of these women were experiencing psychological distress as a result of the decrease in their perception of functional social support. A further look at the qualitative responses did not confirm this but did indicate that some of these women had additional stressors in

their lives which perhaps heightened their perceptions of functional social support.

Vachon et al. (1982) suggested that:

> ...while the data from their research suggests that social support is a very important concomitant of enduring 'high distress', and may sometimes be a causative agent of such distress, it does not support a claim that lack of social support always has a causative relationship to 'high distress'. Indeed, it seems unlikely that perceived deficit in social support and psychological distress could ever be cleanly divided into cause and effect, since not only would one intensify the other, but also the causal sequence could differ from individual to individual (p. 787).

A number of explanations are possible for the findings on the relationship between psychological distress and social support in this investigation. 1) There was no previous data available on the level of social support available to the women in the investigation before the death of their husbands thus no baseline on social support could be established. 2) The perceived social support network and perceived functional social support of the women in the investigation were perhaps the result of the normal activities of these women and/or the result of the psychological distress they were experiencing. 3) The social support available to the women experiencing low or no psychological distress during the first year of bereavement was either automatic or forthcoming, offered by the network as part of the normal exchange of the relationship or activated by the bereavement process rather than an

evident psychological need. 4) The social support available to women experiencing high psychological distress was the result of a direct request for needed and more frequent support or that the network identified that there was a need for additional support and gave it. 5) Smaller networks were perhaps as beneficial for some widows as larger networks were for others.

Qualitative findings suggest that the perceived social support network and the perceived functional social support were affecting the psychological distress of the widow (i.e. living arrangements, concerns for family, remarriage and plans for the future). The investigator suspects that other variables such as children at home, religion, concurrent stressors were acting either singly or in combination to provide psychological distress during the first year of bereavement.

Also, because the conceptual model of social support for the investigation did not allow for past coping experiences, concurrent stressors and the change in needs for social support during the first year of bereavement, the theory may not have been comprehensive enough for this investigation.

The environment in Newfoundland and the traditional beliefs and customs have perhaps made this sample of Newfoundland women respond differently than others to bereavement. The social environment with its expectations may be playing a part in response to bereavement and may account for the

nature of the relationship between psychological distress and social support here in Newfoundland. The investigator noted that during the interviews, the women were very anxious to share their experiences and feelings regarding their response to bereavement. It may be that these women were looking for reassurance regarding their feelings that they were not alone, or that they were experiencing loneliness. Many of the women stated that they felt better after the interviews and expressed eagerness to offer advice and suggestions through their experiences so that others might benefit. Some of the women offered to be available to other widows if a situation arose that their help was beneficial.

In this investigation, the Norbeck Social Support Questionnaire was used; however, findings lead to some questions regarding the instrument. 1) Do the variables affect and aid on the Total Functional Subscale actually measure the perceptions of functional social support in this population? 2) Can the NSSQ provide a comprehensive analysis of the perceived social support network of the widow? 3) Is the NSSQ comprehensive enough to include a conceptualization of social support that is relevant to this population (i.e. some items were not included in the NSSQ which were relevant to this population - beliefs, ideas, groups, things)? These questions have been raised by this investigation but may be of a more general nature.

Kahn and Antonucci's theory stating that social support is heightened when a person's life role undergoes change was not supported in this investigation. The theory suggesting that social support is a buffer between the death of the spouse and the level of psychological distress was also not supported. The findings revealed no support for the buffering hypothesis. As Lenz et al. (1986) reporting a study of social support in new mothers suggest that: "the current research contributes to the cumulating evidence that direct effects of social support may be more important than buffering, and require increased theoretical attention" (p. 23).

Summary

Although the hypothesized relationships between psychological distress and social support were not supported in this investigation, the nature of the sample revealed an interesting perspective on how women in the St. John's area of Newfoundland responded to bereavement. Concurrent stressors were identified as affecting psychological distress. There appeared to be considerable shifting of the social support network during the first year of bereavement. This was not determined to be associated with psychological distress in this investigation. Although women living alone had lower psychological scores than women living with others, they were identified as being at higher at risk for disease and death.

Questions were raised regarding how the social support network operates and the effect to which the supportiveness of any particular network varies with specific situation or needs of the individual. Are smaller networks as beneficial for some widows as larger networks are for others? As the women responded differently in terms of the psychological distress level for the sample and perceived social support, the investigator suggests that there is a social model or role present in the lives of these women in response to bereavement. The nature of the environment here in Newfoundland and the strong family bonds and friendship ties support this suggestion.

CHAPTER VI

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

Summary

The purpose of this investigation was to describe a sample of middle-aged widows and to determine the nature of the relationship between psychological distress and social support during the first year of bereavement. In this descriptive, correlational, prospective investigation, the sample was 30 women aged 45-64 whose husbands had died within a seven month period. During the first year of bereavement, two interviews were conducted: Interview I during the first three to six months of bereavement, and Interview II six months later.

Psychological Distress was measured using the 30-item Goldberg General Health Questionnaire. A score of 5 or more was taken to indicate psychological distress. The women's psychological distress scores decreased from Interview I ($\bar{x}$ = 6) to Interview II ($\bar{x}$ = 3). Three groups of women were identified at the end of the first year of bereavement: those women who reported high psychological distress scores throughout the first year of bereavement (n = 4), those women who reported low psychological distress scores throughout the first year of bereavement (n = 14), and those women who initially had high psychological distress scores which

decreased to low psychological distress scores by the end of the first year of bereavement (n = 11).

Two dimensions of social support, perceived social support network and perceived functional social support, were measured using the Norbeck Social Support Questionnaire. The score on perceived social support network increased from Interview I ($\bar{x}$ = 124) to Interview II ($\bar{x}$ = 131). The scores on perceived functional social support also increased from Interview I ($\bar{x}$ = 236) to Interview II ($\bar{x}$ = 252). There was a positive significant statistical correlation between perceived social support network and perceived functional social support. There was no significant statistical correlations between psychological distress and social support. The women in the sample identified family and friends as their main sources of social support.

The author-constructed Widow Interview Guides (I and II) provided description of the background and personal characteristics, the physical and psychological health characteristics and the social characteristics of the widow and a description of the widow's perception of the first year of bereavement and the problems and difficulties she encountered. Many of the responses on the Widow Interview Guides (I and II) complemented the responses on the GHQ and NSSQ. The women in the sample stated that loneliness was their most serious problem. Many of the women reported difficulty with sleeping and for some of the women, this

continued throughout the first year of bereavement. Using the dependent variable psychological distress in a regression analysis with selected characteristics of the sample as well as the two components of social support (perceived social support network and perceived functional social support), difficulty with sleeping accounted for 37% of the variance at six months of bereavement and 45% of the variance by the end of the first year of bereavement.

Case studies integrated some of the major findings and provided a comprehensive view of the Newfoundland widow's first year of bereavement.

Implications and Recommendations

Nursing Practice

The observation that half of the women were experiencing high psychological distress during the first six months of bereavement suggest that nurses need to be aware of the risks associated with coping with the death of a spouse and have a greater understanding of the bereavement process. Nurses should pay particular attention identifying widows among their clients and to the identification of the early signs of health problems in the widowed person and be prepared to be involved in educating the widowed person to existing resources that are available.

Secondly, nurses should maintain contact with the widows and their families of men who died "in their care" in

spite of the fact that may appear to be managing very well. The nurse could be involved in making needed referrals if necessary and acting as a professional and social contact which might be very helpful to the widowed person. The widowed person is very likely to experience different concerns over time which might be readily shared with a nurse with whom she had established a good relationship.

Nurses need to be cautious in assisting those widows whom they perceive to be coping well. Interestingly, the women in this investigation increased their perceived functional social support network and perceived social support during the first year of bereavement. Yet, a number of these women were experiencing high psychological distress during this period of time also. For example, 50% of the sample in this investigation were experiencing high psychological distress during the first six months of the first year of bereavement.

The nurse also needs to be aware that most widows experience difficulty with sleeping during the first year of bereavement and the health implications of this problem. Suggestions for alternative measures other than medications need to be explored with the widowed person.

Finally, since an aspect of loss of a spouse is a disruption of social roles and social networks and since the literature reports that the widowed are at higher risk of morbidity and mortality, these individuals should be assessed for mental, physical health, social and economic resources

relatively early after bereavement. The public health nurse needs to report and assess surviving spouses just as she assesses the home situation of the newborn child. The finding in this investigation that most members of the helping professions (i.e. health care providers, counsellors or therapists) were almost absent from the support systems of the widows could indicate a need for putting the helping professions in touch with the bereaved instead of waiting for the bereaved to make contact with them.

The following are recommendations for nursing practice:

1. Health care professionals need to take an active role in assessing the needs of widows, and identify those who may be at somewhat higher risk of illness, as well as designing interventions that will assist them in helping the widows reintegrate their lives.

2. Individual physical, psychological and social assessment of the needs of each bereaved person immediately after the death of the spouse (e.g. within the first month of bereavement) seems indicated as there is considerable variety in the response to bereavement.

3. Nursing needs to focus on the personal resources available to the person, such as sources of social support network and health concerns since these may have an important influence on the performance of positive health practices.

4. Nurses need the ability to assess the widow's perception of the kind and amount of support needed (such as aid, information and services), as well as assist the widow to identify creative ways of encouraging the use of available supports.

Nursing Theory and Research

The multidimensional nature of Kahn and Antonucci's concept and model of social support was useful as it guided the investigator to examine the two components of social support: perceived social support network and perceived functional social support. On the basis of the data from this investigation, the investigator questions whether the operationalized definition of social support was comprehensive enough to include other areas of social support which are important to those who have lost a spouse (e.g. groups, ideas, beliefs, places and things). These are items which were not included or were not measured in Norbeck's operationalization of social support utilized in this investigation.

Although not examined in the present investigation, there may have been an interaction effect operating whereby the relationship between psychological distress, perceived social support network and perceived functional social support differed for widows with different characteristics, individual psychological distress levels, concurrent stressors and past coping responses. Small networks may have been as beneficial for some widows as larger networks were for others. Importantly, all widows reported access to social support networks and perceived functional social support from these networks. Since support was measured after the event of the loss of the spouse, previous perceived social

support network and perceived functional social support could not be determined to evaluate the present social support available.

Given the sequence of the variables in the model (social support affecting psychological distress), the more intensely others provided support, the less would be the level of psychological distress. A likely explanation, which could not be examined in this investigation, is that a reverse sequence (psychological distress affecting social support) occurred, whereby the level of psychological distress stimulated widows to request or network members to provide more frequent social support. Since the individual's sense of well being must be maintained regardless of the level of psychological distress, it is possible that widows mobilized their available networks to provide social support or that the network members offered to intensify their involvement when the widow's psychological distress was high.

While the conceptual framework for the investigation did assist in the analysis and categorization of the widows' responses, the investigator suspects that certain alterations in the framework might enhance its use with this population of widows. For example, concurrent stressors such as family problems and/or past coping responses might be included to more aptly describe the situation of bereavement.

There was some duplication in the social characteristics of the widow and the perceived social support network and

perceived functional social support in the conceptual model for the investigation. This duplication was necessary in this investigation to specifically distinguish between the social characteristics and the social network properties of the widow's social support. The design of the investigation included two sets of questions that appear to tap similar domains: the Norbeck Social Support Questionnaire described both perceived network and perceived functional social support; the questions in the Widow Interview Guides asked women to describe the persons they were seeing and from whom they had received assistance at the time of the husband's death. This was additional information which was not specific to the Norbeck Social Support Questionnaire and yet was necessary to have a more thorough understanding of the widow's social characteristics during the first year of bereavement.

Modifications to the Kahn & Antonucci model in addition to those made for this investigation would be to group the individual characteristic categories and including a separate category of concurrent stressors and past coping responses. It is suggested that the background and personal characteristics, the physical and psychological health characteristics and the social characteristics be combined into one category: widow's characteristics. This would allow comprehensiveness of the characteristics and less segregation of data. Kahn & Antonucci segregated this proposed category into properties of the person (age, other demographic characteristics,

personality, etc.) and properties of the situation (expectations and demands of work, family and other roles, etc.). Concurrent stressors and past coping responses might be identified as two separate categories; these together with the widow's characteristics would comprise the component requirements for social support.

Regarding the investigation's methodology and design, the investigator was pleased with the combined qualitative-quantitative aspects of the investigation, as the qualitative aspects enhanced the quantitative findings and provided for a more indepth view of the bereavement process. The qualitative findings also reinforced some of the quantitative results and helped to provide a humanistic perspective to the investigation.

All the instruments used in this investigation appeared sensitive and provided important information which adds to existing nursing knowledge. A clear picture of the psychological status of the women experiencing the loss of a spouse evolves from the results of the GHQ. In this investigation, this instrument appeared both sensitive and comprehensive. The Widow Interview Guides I and II were extremely useful in gathering qualitative data on the process of bereavement. The retrospective section of the Widow Interview II was extremely useful in gathering additional information on the overall response to the loss of a spouse. Many of the responses on the physical and psychological health characteristics and

the social characteristics on the Widow Interview Guides I and II complemented the responses on the GHQ and NSSQ. The loss items at the completion of the NSSQ were not relevant to this investigation and although they were measured, they were not analyzed. A more comprehensive instrument other than the NSSQ measuring the two specific components of social support (i.e. social support network and functional social support) would be beneficial both in assessment for nursing practice and further research.

There is a need for further research concerning the needs and concerns of the widowed person. From the data of the present investigation emerge several projects which could be undertaken:

1. Because the processes associated with the first year of bereavement take longer to complete, then provisions in another research investigation should be made for a two year follow-up interview.

2. This investigation dealt with widows who had lost their husbands. A similar investigation might be conducted with widowers who have lost their wives.

3. Because other investigations have been in urban populations and this investigation was limited to one geographical location, it would be interesting to repeat this in another relatively small urban area or perhaps in a rural population.

4. This investigation dealt with middle-aged widows and since there is a higher proportion of women who are widowed over 65, it would be interesting to repeat this investigation in the older bereaved population in Newfoundland.

These potential studies could provide for a more comprehensive picture of the process of bereavement in Newfoundland and add to the nursing profession's knowledge base on how individuals cope with death and survive the first few years of bereavement.

As with other current studies investigating social support, this investigation revealed that social support is a complex concept requiring multiple measures of its many dimensions. Nurses have a responsibility to explore this complicated concept as it relates to patients in all aspects of life. Only by broadening the nursing knowledge base regarding patients' response to life events can nurses possibly provide that quality of care that the profession strives so hard to deliver.

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APPENDIX A

MEMORIAL UNIVERSITY OF NEWFOUNDLAND
St. John's, Newfoundland. Canada A1C 5S7

School of Nursing
Telephone: (709) 737-6695

Telex: 016-4101
Enquiries: (709) 737-8000

Dear Mrs.

This letter is coming to you because you have recently lost your husband. Many health care professionals are becoming increasingly concerned about widows and how they adjust to widowhood. Because of my interest in this area, I obtained your name from the newspaper.

I am a nurse completing a master's degree in nursing at Memorial University. As part of the requirement for this degree, I am interviewing widows in order to find out how nurses and others can better help widows during their bereavement. Provided you are willing, I wish to interview you at your home within six months after the death of your husband and again at six months following the initial interview.

I am interested in how the middle-aged widow manages personally and socially during bereavement. This information will assist nurses in identifying concerns of widows and their families. You may not directly benefit from participation in the study, but the information may be helpful in providing better care to others who will share a similar experience.

During the first interview I will be asking questions regarding your health and general well-being since your husband passed away. I am also interested in whether others are helping you in various ways and what these might be. The second interview at home will consist of questions about how you've been getting along since your husband passed away and repeat some questions about your well-being. Both interviews are expected to last approximately 60 - 90 minutes each. Most of the interview time will be conversational. You are free at any time not to answer any questions or to withdraw from the study.

In the study and research report, information you give me will be combined with that of other widows who have lost their husbands recently. All information will be kept in strict confidence. Your name will not be recorded with your answers; nor will it be possible to identify you as an individual directly or indirectly in any report.

It is hoped that your participation in the study could help others who will go through the same experience.

. . . 2

I will be calling you within a short time to answer questions about this study and explain in a more personal way about it. Then I will ask if you wish to participate in the study and, if so, to arrange an appointment for an interview in your home or other convenient place.

Your time and interest in consideration of this request is appreciated. I will look forward to an opportunity to talk with you when I call.

Sincerely,

Kathryn Ann Hustins

APPENDIX B

WIDOW CONSENT FORM

I ________________________________, consent to participation in Kathryn Ann Hustins' study of widows and their support system during early bereavement.

I understand that the agreement allows Kathryn Ann Hustins to interview me for 60 - 90 minutes in my home at two points in time.

I understand that my name will not be recorded with my answers nor will it be possible to identify me as an individual directly or indirectly in any report.

I understand that I may refuse to answer any questions or that I am free to withdraw from the interview at any time if I experience any emotional upset.

I understand that during every third interview a portion of the questions and my responses will be tape recorded.

I understand that while I will not directly benefit from participation in the study; the information may be helpful in identifying concerns of other future widows.

Date ____

Widow's Signature ____________________________

Investigator's Signature ______________________

Investigator's Telephone No. __________________

SOCIAL SUPPORT QUESTIONNAIRE

PLEASE READ ALL DIRECTIONS ON THIS PAGE BEFORE STARTING.

Please list each significant person in your life on the right. Consider all the persons who provide personal support for you or who are important to you.

Use only first names or initials, and then indicate the relationship, as in the following example:

Example:

	First Name or Initials	Relationship
1.	MARY T.	FRIEND
2.	BOB	BROTHER
3.	M. T.	MOTHER
4.	SAM	FRIEND
5.	MRS. R.	NEIGHBOR

etc.

Use the following list to help you think of the people important to you, and list as many people as apply in your case.

- — spouse or partner
- — family members or relatives
- — friends
- — work or school associates
- — neighbors
- — health care providers
- — counselor or therapist
- — minister/priest/rabbi
- — other

You do not have to use all 24 spaces. Use as many spaces as you have important persons in your life.

WHEN YOU HAVE FINISHED YOUR LIST, PLEASE TURN TO PAGE 2.

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University of California, San Francisco
Revised 1982

For each person you listed, please answer the following questions by writing in the number that applies.

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 1:

How much does this person make you feel liked or loved?

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____
17. ____
18. ____
19. ____
20. ____
21. ____
22. ____
23. ____
24. ____

Question 2:

How much does this person make you feel respected or admired?

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____
17. ____
18. ____
19. ____
20. ____
21. ____
22. ____
23. ____
24. ____

GO ON TO NEXT PAGE

[7-9]

[10-12]

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 3:

How much can you confide in this person?

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____
17. ____
18. ____
19. ____
20. ____
21. ____
22. ____
23. ____
24. ____

Question 4:

How much does this person agree with or support your actions or thoughts?

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____
17. ____
18. ____
19. ____
20. ____
21. ____
22. ____
23. ____
24. ____

GO ON TO NEXT PAGE

[13-15] [16-18]

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 5:

If you needed to borrow $10, a ride to the doctor, or some other immediate help, how much could this person usually help?

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______
13. ______
14. ______
15. ______
16. ______
17. ______
18. ______
19. ______
20. ______
21. ______
22. ______
23. ______
24. ______

Question 6:

If you were confined to bed for several weeks, how much could this person help you?

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______
13. ______
14. ______
15. ______
16. ______
17. ______
18. ______
19. ______
20. ______
21. ______
22. ______
23. ______
24. ______

GO ON TO NEXT PAGE

[19-21] [22-24]

APPENDIX C

Number ______________ [1-4]
Date ______________

Question 7:

How long have you known this person?

1 = less than 6 months
2 = 6 to 12 months
3 = 1 to 2 years
4 = 2 to 5 years
5 = more than 5 years

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______
13. ______
14. ______
15. ______
16. ______
17. ______
18. ______
19. ______
20. ______
21. ______
22. ______
23. ______
24. ______

[25-27]

Question 8:

How frequently do you usually have contact with this person? (Phone calls, visits, or letters)

5 = daily
4 = weekly
3 = monthly
2 = a few times a year
1 = once a year or less

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______
13. ______
14. ______
15. ______
16. ______
17. ______
18. ______
19. ______
20. ______
21. ______
22. ______
23. ______
24. ______

[28-30]

PERSONAL NETWORK

	First Name or Initials	Relationship	
1.	______	______	[32]
2.	______	______	[33]
3.	______	______	[34]
4.	______	______	[35]
5.	______	______	[36]
6.	______	______	[37]
7.	______	______	[38]
8.	______	______	[39]
9.	______	______	[40]
10.	______	______	[41]
11.	______	______	[42]
12.	______	______	[43]
13.	______	______	[44]
14.	______	______	[45]
15.	______	______	[46]
16.	______	______	[47]
17.	______	______	[48]
18.	______	______	[49]
19.	______	______	[50]
20.	______	______	[51]
21.	______	______	[52]
22.	______	______	[53]
23.	______	______	[54]
24.	______	______	[55]

[5-6]

PLEASE BE SURE YOU HAVE RATED EACH PERSON ON EVERY QUESTION. GO ON TO THE LAST PAGE.

9. During the past year, have you lost any important relationships due to moving, a job change, divorce or separation, death, or some other reason? [57]

_________ 0. No
_________ 1. Yes

IF YES:

9a. Please indicate the number of persons from each category who are *no longer available* to you.

_________ spouse or partner [58]
_________ family members or relatives [59-60]
_________ friends [61-62]
_________ work or school associates [63-64]
_________ neighbors [65-66]
_________ health care providers [67]
_________ counselor or therapist [68]
_________ minister/priest/rabbi [69]
_________ other (specify) _______________________ [70] [71-72]

9b. Overall, how much of your support was provided by these people who are no longer available to you? [73]

_________ 0. none at all
_________ 1. a little
_________ 2. a moderate amount
_________ 3. quite a bit
_________ 4. a great deal

APPENDIX D

GENERAL HEALTH QUESTIONNAIRE

PLEASE READ THIS CAREFULLY:

We would like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by circling the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past. It is important that you try to answer ALL the questions. Thank you very much for your cooperation.

HAVE YOU RECENTLY:

1. been able to concentrate on whatever you're doing?	Better Than Usual	Same As Usual	Less Than Usual	Much Less Than Usual
2. lost much sleep over worry?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
3. been feeling mentally alert and wide awake?	Better Than Usual	Same As Usual	Less Alert Than Usual	Much Less Alert
4. been feeling full of energy?	Better Than Usual	Same As Usual	Less Energy Than Usual	Much Less Energetic
5. been having restless, disturbed nights?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
6. been managing to keep yourself busy and occupied?	More So Than Usual	Same As Usual	Rather Less Than Usual	Much Less Than Usual
7. been getting out of the house as much as usual?	More Than Usual	Same As Usual	Less Than Usual	Much Less Than Usual
8. been managing as well as most people would in your place?	Better Than Most	About The Same	Rather Less Well	Much Less Well
9. felt on the whole you were doing things well?	Better Than Usual	About The Same	Less Well Than Usual	Much Less Well
10. been able to feel warmth and affection for those near to you?	Better Than Usual	About Same As Usual	Less Well Than Usual	Much Less Well

11. been finding it easy to get on with other people?	Better Than Usual	About Same As Usual	Less Well Than Usual	Much Less Well
12. felt that you are playing a useful part in things?	More So Than Usual	Same As Usual	Less Useful Than Usual	Much Less Useful
13. felt capable of making decisions about things?	More So Than Usual	Same As Usual	Less So Than Usual	Much Less Capable
14. felt constantly under strain?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
15. felt you couldn't overcome your difficulties?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
16. been finding life a struggle all the time?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
17. been able to enjoy your normal day-to-day activities?	More So Than Usual	Same As Usual	Less So Than Usual	Much Less Than Usual
18. been taking things hard?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
19. been getting scared or panicky for no good reason?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
20. been able to face up to your problems?	More So Than Usual	Same As Usual	Less Able Than Usual	Much Less Able
21. found everything getting too much for you?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
22. been feeling unhappy and depressed?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
23. been losing confidence in yourself?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual

24. been thinking of yourself as a worthless person?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
25. felt that life is entirely hopeless?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
26. been feeling hopeful about your own future?	More So Than Usual	About Same As Usual	Less So Than Usual	Much Less Hopeful
27. been feeling reasonably happy, all things considered?	More So Than Usual	About Same As Usual	Less So Than Usual	Much Less Than Usual
28. been feeling nervous and hung-up all the time?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
29. felt that life isn't worth living?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual
30. found at times you couldn't do anything because your nerves were too bad?	Not At All	No More Than Usual	Rather More Than Usual	Much More Than Usual

APPENDIX E

Widow Interview Guide 1 (I_1)
(First Six Months Into Bereavement)

Code Number: ___ ___

Time Began: AM
PM

INTRODUCTION

I would like to ask you some questions about yourself, your husband and how you are getting along with your usual activities since the death of your husband. In order for me to be sure that I remember what you say, I may be recording some of your answers. Your name does not appear on this record. You may find some questions are personal. If you would rather not answer some of the questions, please feel free to say so.

Card 1-1

How old are you? ___ ___

Where were you born? ___ ___

Newfoundland
Other Province of Canada
Outside of Canada

How far did you go in school? ___

Do you have any brothers and sisters? ___

How many? ___ ___

What position were you in your family? ___

Are your mother or father still living? ___

Card 1-2

What is your religious preference: ___

Roman Catholic
Protestant (specify)
Jewish
Other
No Preference

How often do you attend religious services? ___

Would you say...

daily
several times a week
about once a week
several times a month
about once a month
several times a year
about once a year
less than once a year
never

Religious beliefs:
- about death
- life after death

Card 1-3

Husband's age at death? ___ ___

Where was your husband born? ___ ___

Did your husband have brothers and sisters? ___
- how many ___ ___

Husband's occupation? ___

How long were you married? ___ ___

Was it a first marriage for you? ___
- for your husband? ___

How many children do you have? (alive) ___ ___
- # under 18 ___ ___

Are you working now? ___
a) occupation ___
b) full or parttime ___
c) what about future plans? ___
continuing working
or going to work

Card 1-4

What did your husband die of? ___
(What was the official cause of death?)

How long was your husband hospitalized? ___ ___
(record months)

Was your husband ill a long time before he
was hospitalized? ___ ___
(record months)

Did you discuss the impending death with
your husband? ___

How did you feel when you knew he had gone? ___

Card 1-5

How has your health been since your husband
passed away? ___

Have you had professional help from a
medical Doctor? ___
- Psychiatrist? ___

Did you in the previous year? ___

Do you or did you have to take any tranquilizers
or sleeping pills since your husband died? ___

Do you feel that it is difficult for you to do
things now? ___

(If yes) - What kind of things do you find
difficult to do? ___

Are you eating and sleeping with any difficulty? ___

Compared to the time before the death of your
husband, do you now:

drink more   less   the same ___

smoke more   less   the same ___

Have you gained or lost weight or remained
the same? ___

Card 1-6

Do you see now some of your close friends?
- (If yes) whom do you see? (e.g. individual) ___
- how often? ___

Do you see some of your husband's friends?
- (If yes) whom do you see? (e.g. individual) ___
- how often? ___

Do you see frequently any member of your family?
- (If yes) whom do you see? (e.g. individual) ___
- how often? ___

Do you see some of your husband's family?
- (If yes) whom do you see? (e.g. individual) ___
- how often? ___

Have you made any new friends?
- (If yes) who are they? (e.g. individual) ___

Have you become closer to certain people since your husband died?
- (If yes) who are these people? (e.g. individual) ___

Are there some people you do not see as frequently as you used to? ___
- (If yes) Who are these people? (e.g. individual) ___

Do you turn to anyone in particular to discuss any problems you may have now? ___
- (If yes) whom do you turn? (e.g. individual) ___

Was there anyone who was especially helpful to you when your husband died? ___
- who? (e.g. individual) ___

Who took care of the arrangements for the funeral? (e.g. individual) ___

Card 1-7

Have you experienced death before?
- who? (e.g. individual) ___

What about mourning rituals? ___
- how supportive were they? ___

Have you applied for Canada Pension? ___

What was your approximate monthly income
before your husband's death? ___ ___ ___ ___

Can you give me an estimate of your
approximately monthly income now? ___ ___ ___ ___

Card 1-8

End of Interview

What do you find yourself thinking about these days?

Finally, is there anything else that you wish to tell me?

Card 1-9

To be filled out immediately after leaving respondent.

1. Total length of interview:
   - (record minutes) ___ ___ ___

2. Were there other people present during the interview: family members ___
   other than family members ___

3. Did any of the others present take part in the interview or did respondent seek advice or opinion from any of them? ___

4. Does respondent have any physical or mental handicaps? ___

5. Was respondent emotionally upset during the interview? (e.g. crying, depressed) ___

6. Inside appearance of home: ___

7. Outside appearance of home: ___

8. Respondent's reaction during interview:
   silent..........talkative ___
   friendly........hostile ___

9. Respondent's appearance: ___

10. Date of interview:

APPENDIX F

Widow Interview Guide 2 (I_2)

(Second Six Months Into Bereavement)

Code Number ___ ___

Time Began: AM
PM

INTRODUCTION

I would like to ask you some questions about how you've been getting along with your usual activities since you husband passed away. In order for me to be sure I remember what you say, I may be recording your answers. Again, I remind you, your name does not appear on this record. You may find some questions are personal. If you would rather not answer some of the questions, please feel free to say so.

Card 2-1

What has been your most serious problem since your husband died?

What is the greatest change you have experienced in your daily life since your husband passed away?

Is there anything you have to do without because you cannot afford it?

Have you talked to other women who lost their husbands?

Has this been helpful?

Looking back, is there any decision you took since your husband passed away that you now regret?

Looking back, is there any decision you took since your husband passed away that you feel was an especially wise one?

Card 2-2

Have you any advice you could give which may be useful to other women in the same circumstances?

How has the loss of your husband's work affected you besides loss of income?

- loss of status
- loss of friends
- any other changes

What brings back painful memories?

- seeing husband's colleagues
- visiting hospital where husband died

Do you feel that going through this difficult period has changed your religious feelings?

- What brought about this change?

Card 2-3

How did the passing away of their father affect your children?

What is now your main concern about your children?

Has it affected their schooling?

Have the educational plans of your children been changed?
- (If yes) in which way?

To whom would you turn now, if you had a problem about your children?

Card 2-4

How has your health been since I last interviewed you?

Have you had professional help from a medical Doctor?
- Psychiatrist?

Do you or did you have to take any tranquilizers or
sleeping pills?

Do you feel that it is difficult for you to do things now?
- (If yes) What kind of things do you find difficult to do?

Are you eating and sleeping with any difficulty?

Compared to the time before the death of your husband, do you now:

drink more	less	the same
smoke more	less	the same

Have you gained or lost weight or remained the same?

Card 2-5

Do you see now some of your close friends?
- (If yes) whom do you see?
- how often?

Do you see some of your husband's friends?
- (If yes) whom do you see?
- how often?

Do you see frequently any member of your family?
- (If yes) whom do you see?
- how often?

Do you see some of your husband's family?
- (If yes) whom do you see?
- how often?

Have you made any new friends?
- (If yes) who are they?

Have you become closer to certain people since your husband died?
- (If yes) who are these people?

Are there some people you do not see as frequently as you used to?
- (If yes) who are these people?

Do you turn to anyone in particular to discuss any problems you may have now?
- (If yes) whom do you turn?

Is there anyone who has been especially helpful to yousince your husband died?
- (If yes) who?

Card 2-6

End of Interview

What do you find yourself thinking about these days?

Finally, is there anything else that you wish to tell me?

Card 2-7

To be filled out immediately after leaving respondent:

1. Total length of interview:
   (record minutes) ___ ___ ___

2. Were there other people present during
   the interview: family members ___
   other than family members ___

3. Did any of the others present take part
   in the interview or did respondent seek
   advice or opinion from any of them? ___

4. Does respondent have any physical or
   mental handicaps? ___

5. Was respondent emotionally upset during
   the interview? (e.g. crying, depressed)
   ___

6. Inside appearance of home: ___

7. Outside appearance of home: ___

8. Respondent's reaction during interview:
   silent..........talkative ___
   friendly........hostile ___

9. Respondent's appearance. ___

10. Date of interview.

APPENDIX G

The Newfoundland Women's Network During the First Year of Bereavement (N = 30)

Client	Women's Network Interview I								Women's Network Interview II							
	Family/Relatives	Friends	Work/School Associates	Neighbours	Health Care Providers	Counsellor/Therapist	Minister/Priest/Rabbi	Number in Network	Family/Relatives	Friends	Work/School Associates	Neighbours	Health Care Providers	Counsellor/Therapist	Minister/Priest/Rabbi	Number in Network
001	1	3						4	3	3						6
002	5	2						7	10	1						11
003	12	2					1	15	18	2					1	21
004	17	2						19	13	5						18
005	7	1						8	15	8		1				24
007	2	4			2	3	1	12	2	4			1	2	1	10
008	5	1		1			1	8	3	1	1	2			1	8
009	13	4						17	11	1						12
010	4							4	8			4				12
011	4	5			1		1	11	14	4		1			1	20
012	2	3		1				6	4	3						7
013	7	6						13	7	6						13
014	4	3					1	8	7	5					1	13
015	13	8	1	2				24	4	4						8
016	9	12			1		2	24	5	6		2			2	15
017	9	2						11	9	3						12
018	6	1						7	7	1	1				1	10
019	17	5						22	12	2	2					16
020	6	4					3	13	4	8		1				13
021	8	6		9			1	24	12	6	2	2	1		1	24
022	4	13					2	19	2	8		3			3	16
023	4	4		1				9	3	3						6
025	6	3		3			1	13	7	4					1	12
026	5	4			3			12	7	5	5	1	5			23
027	6	4						10	9	1						10
028	6	2						8	7			3	1		1	12
030	9	4						13	8	1			1			10
031	11	2						13	7	1					1	9
032	4	3					1	8	5	2						7
033	8	6						14	8	6						14

APPENDIX H

Means, Standard Deviations and Range Scores for Total Network Subscale Variables on NSSQ During the First Year of Bereavement (N = 30)

Total Network subscale variables	Interview I $\bar{X}$	I S.D.	I Range	Interview II $\bar{X}$	II S.D.	II Range
Number listed in network	12.53	5.79	4-24	13.07	5.20	6-24
Frequency of contact	51.40	25.09	17-108	53.67	22.94	23-101
Duration of relationship	60.33	28.32	20-120	63.77	25.92	29-120
Total Network subscale[a]	124.27	58.67	41-252	130.50	53.55	59-245

a Total Network Subscale Σ number in network
Σ frequency of contact score
Σ duration of relationship score

APPENDIX I

Means, Standard Deviations and Range Scores for Total Functional Subscale Variables on NSSQ During the First Year of Bereavement (N = 30)

Total Functional subscale variables	Interview I $\bar{X}$	I S.D.	I Range	Interview II $\bar{X}$	II S.D.	II Range
Affect						
1. Liked or loved	42.33	22.52	12-96	44.00	18.18	14-79
2. Respected or admired	41.33	24.33	8-96	42.23	18.95	14-92
Affirmation						
3. Confident	36.80	19.25	12-88	42.00	17.83	15-89
4. Agree & support	41.20	24.44	12-96	43.10	19.37	9-89
Aid						
5. Immediate help	41.80	24.72	8-96	44.80	20.19	18-96
6. If you were patient	32.43	21.87	0-93	33.77	16.77	9-71
Total Functional subscale[a]	235.90	130.38	68-523	251.90	105.18	87-487

a Total Functional Subscale Σ affect score
Σ affirmation score
Σ aid score

APPENDIX J

Correlations[a] Between Background and Personal Characteristics of the Women and Psychological Distress Experienced by the Women During the First Year of Bereavement (N = 30)

Background and Personal Characteristics and Psychological Distress	Correlation
Age	217.08
Parent still living	15.62
Attendance at religious services	41.05
Length of marriage	272.71
Children under 18	36.66
Future work plans	9.86
Perception cause of death	44.67
Length of time husband ill	103.36
Discuss impending death with husband	12.74
Experience death before	13.63
Monthly income before death	211.00
Monthly income after death	206.13
Driving status	15.95

a Correlations are chi-square
$p < .05$

APPENDIX K

Correlations[a] Between Physical and Psychological Health Characteristics of the Women and Psychological Distress Experienced by the Women During the First Year of Bereavement (N = 30)

Background and Personal Characteristics and Psychological Distress	Correlation	
	Interview	
	I	II
Health since husband died	17.25	15.85
Professional help from physician	13.74	5.18
Professional help from psychiatrist	21.67	17.95*
On medications since death of husband	23.99	12.19
Feel that it is difficult to do things	15.26	13.32
Difficulty concentrating	7.39	13.00*
Difficulty making decisions	13.65	7.13
Difficulty working	7.46	2.43
Difficulty with activities of daily living	12.31	3.40
Difficulty meeting people	13.19	
Difficulty eating	22.76*	14.48
Difficulty sleeping	21.47	16.61*
Difficulty drinking	43.31	7.58
Difficulty smoking	35.46	24.80
Difficulty with weight	51.84	13.40

a Correlations are chi-square
* $p < .05$

APPENDIX L

Correlations[a] Between the Social Characteristics of the Women and Psychological Distress Experienced by the Women During the First Year of Bereavement (N = 30)

Social Characteristics and Psychological Distress	Correlation	
	Interview	
	I	II
See or talk with close friends	7.23	1.79
See or talk with husband's friends	16.95	5.86
See or talk with family members	14.26	
See or talk with members of husband's family	12.27	2.15
Made any new friends	26.27*	5.09
Closer to certain people	9.51	9.35
See some people less frequently	7.81	6.19
Turn to anyone in particular	4.74	17.95*

a Correlations are chi-square
* $p < .05$

APPENDIX M

Scores Yielded by the Norbeck Social Support Questionnaire

Variables	Kirschling's Recently Widowed (1984) N = 67			Norbeck's Respondents (1982) N = 136		Investigation's Respondents N = 30					
						Interview					
						I			II		
	Mean	St.Dev.	Range	Mean	St.Dev.	Mean	St.Dev.	Range	Mean	St.Dev.	Range
Affect	101.72	66.68	7-341	98.03	46.69	83.67	46.64	21-192	88.23	36.78	28-171
Affirm	93.24	61.60	6-349	90.59	42.60	78.00	42.50	24-175	85.10	36.47	24-178
Aid	87.37	62.84	8-350	86.90	41.79	74.23	45.43	16-189	78.57	34.86	27-154
Total Functional Subscale	282.33	187.96	24-1040	274.99	126.35	235.90	130.38	68-523	251.90	105.18	87-487
Number Network	11.15	6.75	1-35	12.20	5.49	12.53	5.79	4-24	13.07	53.55	6-24
Duration	53.75	33.40	1-169	53.70	24.96	60.33	28.32	20-120	63.77	25.92	29-120
Frequency	45.88	33.63	4-222	44.56	20.24	51.40	25.09	17-108	53.67	22.94	23-101
Total Network Subscale	110.78	68.29	7-346	110.46	49.18	124.27	58.67	41-252	130.50	53.55	59-245

APPENDIX N

Correlations[a] Between the Major Variables Under Study

	Interview I			Interview II		
Interview I	GHQ	TNET	TFunct	GHQ	TNET	TFunct
GHQ (Psychological Distress)		.26	.24	.15	-.18	-.11
Total Network (Perceived Social Support Network)			.94**	-.19	.45**	.38*
Total Functional (Perceived Functional Social Support)				-.10	.51**	.47**
Interview II						
GHQ (Psychological Distress)	.15	-.18	-.11		-.16	-.19
Total Network (Perceived Social Support Network)	-.19	.45**	.38*			.95**
Total Functional (Perceived Functional Social Support)	-.10	.51**	.47**			

a Pearson product-moment correlation co-efficient

* *p* .05

** *p* .01

APPENDIX O

<u>Other Variables Affecting Psychological Distress</u>

Variable	Psychological Distress (GHQ)	
	Interview	
	I	II
Chronic illness	5.6	3.0
Sudden death	7.3	2.2
Perceptions of health		
Worse	12.0	3.0
Just the same	3.7	3.0
Better		2.0
Professional help from a physician		
Yes	8.1	
No	3.8	
Years married		
< 20 years	6.0	
20 years and over	7.0	
Income before husband's death		
< $1000 month	6.0	
$1000 month and over	6.0	
Income before husband's death		
< $1000 month	3.4	
$1000 month and over	1.3	
Age		
< 55	8.0	
55 and over	5.0	
Number in network		
< 10	7.0	3.0
10 and over	6.0	3.0

APPENDIX P

Request Form

I request permission to copy the Norbeck Social Support Questionnaire (NSSQ) for use in research in a study

entitled: ADJUSTMENT TO WIDOWHOOD: AN EXPLORATORY STUDY OF MIDDLE-AGED NEWFOUNDLAND WIDOWS

In exchange for this permission, I agree to submit to Dr. Norbeck a copy of the one-page scoring sheet for each subject tested. These data will be used to establish a broad normative database for the instrument for clinical and non-clinical populations. Aside from use in the pooled data bank, no other use will be made of the data submitted. Credit will be given to me in reports of normative statistics that make use of the data I submitted for pooled analyses.

Kathryn Ann Hurteau
(Signature)

January 7, 1985.
(Date)

Position and Full Address of Investigator: Graduate Student, School of Nursing, Memorial University of Newfoundland, St. John's, Newfoundland, Canada. A1C 5S7

Permission is hereby granted to copy the NSSQ for use in the research described above.

Jane S. Norbeck
Jane S. Norbeck

1/29/85
(Date)

Please send *two signed* copies of this form to:

Jane S. Norbeck, D.N.Sc.
Department of Mental Health and Community Nursing
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N505-Y
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