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WIDOWHOOD: THE RELATIONSHIP BETWEEN SOCIAL SUPPORT, HEALTH AND LONELINESS

by

Linda Mary Scott

A thesis submitted in conformity with the requirements for the Degree of Master of Science, Graduate Department of Nursing Science, in the University of Toronto

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Widowhood: The Relationship between Social Support, Health and Loneliness

Master of Science, 1998

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Abstract

A descriptive correlational study utilizing a convenience sample of 30 elderly widows examined the relationships between the perceived provisions of social support and the dimensions of health, the perceived provisions of social support and loneliness, and loneliness and the dimensions of health. Data were collected during one interview using a Demographic Data Sheet; the Social Provisions Scale, the Health Status Profile -SF-36; and the UCLA Loneliness Scale. Data analysis revealed several positive and strong relationships between the perceived provisions of social support and the dimensions of health. A negative but moderate relationship was found between the provision of attachment in social support and loneliness. Several negative but strong relationships were found between loneliness and the dimensions of health. The results of this study support the literature that links social support to health, and perception of good health to less loneliness. The findings did not support the literature that suggests that the loss of an attachment figure (spouse) leads to the experience of loneliness.
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Acknowledgements

I wish to express my deepest appreciation to all those who have contributed to the completion of this thesis. I wish to thank the members of my thesis committee, Dr. Souraya Sidani, committee chairman, Professor Dorothy Craig, and Ms. Pamela Dawson, for their wisdom, guidance and support.

I would like to thank Aileen and Jenny for their assistance with research materials, and especially to Louise and Karen for their technical expertise.

My sincerest appreciation is extended to those 30 women who welcomed me into their lives and willingly participated in this study. A special thank-you is also extended to those hospice volunteers who assisted in recruiting participants.

I would like to thank my dear son Nicholas, who patiently endured some disruption in his little life while his mother completed her studies. Finally, I am deeply grateful to my husband Gregory who made life easier through his support and generosity, so that I could complete my studies.
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CHAPTER 1

PROBLEM AND PURPOSE

Widowhood is an expectable life event for many women who choose to marry. Women tend to marry men who are older than themselves, live longer than their male counterparts, and are therefore more likely to engage in the transition from married to widowed status at some point in their life time. They are also more likely to experience widowhood for a longer duration than men. Of the 1.3 million widowed men and women in Canada who are over the age of 65, 83% are women. Of the 83%, the age group most highly representative of widowhood status is the 70-79 year range, with a 44% representation (Statistics Canada, 1996). Among the elderly population 65 years and older, widowers are nine times more likely to remarry than are widows, resulting in a larger proportion of elderly widowed women in this country (Martin-Matthews, 1991).

The loss of a partner is believed to be one of the most challenging life experiences requiring not only adaptation to a new role, but many adjustments including a redefinition of self, environment, friends, and family (Ferraro, 1989; Stroebe & Stroebe, 1993). The perception that one has or does not have the support of family and friends can affect the transition from married to widowed
Loneliness, although not specific to old age, is one such potential problem for the widowed elderly (Beck, Schultz, Walton, & Walls, 1990; Weeks, 1994). For many elderly, the loneliness develops from a number of events: children leave home; careers end in retirement; chronic illness limits mobility and social contact; and significant others die. All of these life events can precipitate or enhance the loneliness experience (Walton, Shultz, Beck, & Walls, 1991).

The loss of an intimate relationship is the greatest precipitator of loneliness in later life (Dugan & Kivett, 1994). The loss of a spouse can often lead to poorer physical health by reducing immune function, and predisposing one to disease, (Kim & Jacobs, 1993; Laudenslager, Boccia, & Reite, 1993) as well as increasing the need for hospitalization or placement in a nursing home (Abd-El-Ghany, 1986). It can also lead to poorer mental and social health, and result in health damaging behaviors such as drug and alcohol abuse, smoking, and poor nutritional habits (Stroebe & Stroebe, 1994; Russell, Cutrona, Rose & Yurko, 1984). Loneliness has also been linked to depression and suicide for the bereaved elderly (Burnette & Mui, 1994; Li, 1995; Mullins & Dugan, 1990). The loss of a
spouse can lead to a specific type of loneliness, referred to as an “emotional” loneliness. One can also experience a “social” loneliness, that can only occur when one does not feel part of a group of friends (Weiss, 1973).

The research to date indicates that the loss of a spouse is a challenging and difficult life event (Dimond, Lund & Caserta, 1987; Herth, 1990): that certain types or provisions of social support are necessary in order to reduce the stressors experienced (Russell & Cutrona, 1991); and that those who receive the right type of social support are better off as a result, and thus more likely to report less loneliness and better physical, mental, and social health (Russell, 1996; Weiss, 1973). This study examined the relationships between these types or provisions of social support, health, and loneliness, in elderly widows in order to address the gap in the literature.

**Problem Statement**

The specific problem under investigation in this study is stated in the following question: What is the influence of the perceived provisions of social support and loneliness on the perception of physical, mental, and social health in elderly widows?

**Purpose of the Study**

The immediate purpose of this descriptive correlational study was to
examine the influence of the perceived provisions of social support and loneliness on the perception of physical, mental, and social health in elderly widows aged 60 years and over. It is important to understand the relationship between the perceived provisions of social support, self-rated health status, and loneliness in the elderly widowed population, so that nurses can utilize this knowledge in the assessment of the unique needs of the bereaved older woman and make a contribution to theory.

**Review of Related Research**

The global role of social support in relation to bereavement, overall health, and aging has been studied extensively in the field of gerontology. The following review will address the provisions or (types) of social support and their relationship to loneliness and the physical, mental, and social dimensions of health in widowed elderly women. This review is organized accordingly: (1) The Provisions of Social Support and the Dimensions of Health; (2) The Provisions of Social Support and Loneliness; (3) Loneliness and the Dimensions of Health; (4) Limitations of the Studies Reviewed; (5) Summary of the Literature Review.

**The Provisions of Social Support and The Dimensions of Health**

The positive and strong relationship between social support and health is well documented in the gerontological literature. This relationship has been
explored extensively in studies examining the elderly population (Anderson & Dimond, 1995; Sugisawa, Liang, and Liu, 1994; Ducharme & Rowat, 1992; Lund, Caserta, Van Pelt, & Gass, 1990; Shank & Lough, 1989; Ploeg & Faux, 1989; Krause, 1987; Antonucci, 1985a), and suggest that those who have social support in their lives enjoy better health. However, although older men and women were utilized in these samples, not all of these samples included widows. Social support following the loss of a loved one has been shown to have a protective influence from the detrimental health effects of loss (Stroebe & Stroebe et al., 1996; Cutrona and Russell, 1987; Dimond, Lund, & Caserta, 1987; Warner, 1987; Krause, 1986). In a study of elderly community widows, Krause (1986) found that certain types of social support (informational, tangible, and emotional) had a protective influence against the impact of bereavement on certain depressive symptoms (sadness, loneliness, depression), and certain somatic symptoms (appetite and sleeping difficulties). For example, when informational support was reported to be low (b = 1.94), individuals reported having difficulty sleeping and eating properly. Conversely, when informational support was reported to be high, an inverse relationship was found between it and the problems related to sleeping and eating (b = -.182). Individuals who reported higher informational support, reported fewer problems with sleeping and eating. The results of this study
suggested that social support can protect individuals from the effects of bereavement that can negatively affect their health.

Several studies have suggested that it is the perception of one's social support and not the actual social support someone has (such as the size of the social network), that is related to mental and physical health outcomes (Lakey, McCabe, Fisicaro & Drew, 1996; Russell and Cutrona, 1991; Kanacki et al., 1996; Sutherland & Murphy, 1995; Warner, 1987). In a study examining the relationship between the amount of social support reported and levels of depression in elderly widows (n=31) and widowers (n=35), (X age = 71.8 years), Kanacki et al. (1996), found a significant negative relationship (r = -.41, p<.01) between the amount of perceived social support and depression. Greater levels of perceived social support were related to less depression in both the widows and widowers. These results should be used with caution as the sample size was small.

The Personal Resource Questionnaire, although a reliable instrument for measuring network structure, satisfaction, and other aspects of social support (Brandt & Weinert, 1981), was used in this study, and might not be sensitive enough to measure perceived social support. Coyne and DeLongis (1986), caution that perceived social support is a limited construct in terms of understanding the role that relationships such as marriage and bereavement play in
adaptation. This identification of the limitation of perceived social support stems from the belief that it is the circumstances in which adaptation and perceived social support occur that is important, not just whether or not social support is present and beneficial to the individual (Coyne and DeLongis, 1986).

It should be noted that not all studies see social support as the panacea of all of life’s challenges (Buunk & Hoores, 1992; Tilden & Galyen, 1987; Rook, 1984). In a study on the effects of social relationships on well-being, Rook (1984) studied widowed women (n=120, \( \bar{x} \) age=72.4 years) and found that socializing with others who provided the individual with emotional, tangible, or companionship support was not necessarily related to well-being.

Many studies over the years have noted the decline in health following conjugal bereavement. Role changes and the process of grieving create a challenging situation for the individual that can result in illness (Gass, 1987). Some of the studies have focused on the decline in overall well-being during widowhood (Silverstein & Bengtson, 1994; Lund, Caserta, & Dimond, 1989; Arens, 1982); while others have more closely examined the changes in both physical and mental health status (Parkes, 1977; Lopata, 1973; Rook, 1984; Cutrona & Russell, 1987; Ferraro, 1989; Van Zandt, Mou, & Abbott, 1989; Avis, Brambilla, Vass & Mckinlay, 1991; Gallagher-Thompson, Futterman, Farberow,
Thompson, & Peterson, 1993; Silverstein & Bengtson, 1994; Martikainen & Valkonen, 1996). The major findings of these studies suggest that the bereaved individual is more prone to both physical and psychological illness after the loss of a spouse.

There is empirical support for a strong relationship between social support and health. In a study examining (n=50; $\bar{x}=72.5$ yrs.) community dwelling elders, thirty-three of whom were widows, social support was related to health ($r = .27$; $p<.05$) through the lifestyle variable. Those individuals who felt they had strong social support, engaged in more positive lifestyle behaviours and reported higher levels of health (Ploeg and Faux, 1989).

A study by Gallagher-Thompson et. al (1993), examining the impact of spousal loss on health in (n=212; $\bar{x}=68$ yrs.) widowed elderly compared to (n=164; $\bar{x}=70$ yrs.) older individuals who had not lost a spouse, found the odds of a new or declining health state occurring for the bereaved to be estimated at 1.40 higher than for the nonbereaved. Similarly, Van Zandt, Mou and Abbott (1989), in a study conducted with (n=50; $\bar{x}=70.1$ yrs.) bereaved rural elders, and (n=50; $\bar{x}=70.7$ yrs.) nonbereaved rural elders reported that the bereaved sample had poorer health and experienced more health problems than the non bereaved sample.

In summary, findings from the studies reviewed in this section support the
premise that those widowed women who have strong support systems enjoy better physical and psychological health. Several studies found the perception one held regarding their support system versus the actual support they had, to be a key construct in understanding the relationship of social support to mental and physical health. One article argued that it is more important to understand the role that relationships play in adaptation versus focusing on the construct of perceived social support (Coyne and DeLongis, 1986). One study found the specific type of support widowed women received important to their health outcomes (Krause, 1986), while another found that those individuals with stronger supports were more likely to look after themselves and thus report better health (Ploeg and Faux, 1989). In contrast, Rook (1984) found that in certain situations social support could have negative effects on the health and well-being of the individual. Some of the above studies had small sample sizes and did not exclusively study the elderly widow.

The Provisions of Social Support and Loneliness

The loss of an important attachment relationship in the course of one’s lifetime can lead to a feeling of loneliness. Weiss’s (1974) work has identified six different “relational provisions” required by human beings in order to ameliorate feelings of distress and loneliness: (1) Attachment; (2) Social Integration;
(3) Opportunity for Nurturance; (4) Reassurance of Worth; (5) A Sense of Reliable Alliance; and (6) The Obtaining of Guidance. Furthermore, Weiss identified both emotional and social loneliness as separate constructs existing when two or more of the above provisions are absent from the individual’s life. According to Weiss’s Typology of Relational Provisions, loneliness “is caused not by being alone but by being without some definite needed relationship or set of relationships.... more accurately a response to the absence of some particular relational provision” (Weiss, 1973, p. 17). Thus, the perception that one does not have the necessary support provided from the above provisions can lead to a feeling of loneliness.

Some studies have looked at the relationship between social support and loneliness in both younger and elderly samples (Kaufman & Adams, 1988; Mullins & Dugan, 1990; Wilson, Calsyn, & Orlofsky, 1994; Foxall, Barron, Von Dollen, Shull & Jones, 1994; Beck, Shultz, Walton, & Walls, 1990; Rook, 1987; Pierce, Sarason & Sarason, 1991). There is general agreement that the perception that one has social support can ameliorate feelings of loneliness in ones life. However, even fewer studies have examined the relationship between social support and loneliness in the widowed elderly population (Haas-Hawkings, 1978; Lopata, Heinemann, & Baum, 1982; Stroebe et al., 1996).
In a study examining the relationship of social support to loneliness in a sample of American elderly widows (n=967, $\bar{x}$ age = 69yrs.), Lopata, Heinemann, and Baum (1982) found that family and friendship support systems functioned differently for widows of different ages in relation to loneliness. They found that support from family and friends performed differently for the widows regarding loneliness and that familial support did not necessarily alleviate loneliness for the elderly widow. The nonlonely widow had stronger friendship support ($r=.11, p<.001$). This study also found that among the 60-74 year group of widows, those women who were not lonely were more likely to have strong family and friendship support. In those widows 75 years and older, the lonely were more likely to have family supports and the nonlonely were more likely to have strong friendship supports, thus demonstrating how different types of support from different people can work to decrease or eliminate loneliness. The strength of this study is evidenced in its large sample size. Generalizability of findings is limited because the sample was only representative of low income white elderly widows with limited education.

Dugan and Kivett (1994) examined the relationship of emotional and social isolation to loneliness in a sample of 119 adults living in rural areas. Those widows and widowers who had lost a spouse (58% of the sample), experienced
more loneliness than those who did not lose a significant other, thus making marital status a strong predictor of loneliness (β=.31, p<.01). Social isolation variables identified as whether or not the widows/widowers were visited by children, friends, and siblings, explained only 10% of the variance in loneliness. However, the number of visits with siblings had a significant (β=.21, p<.05) effect, thus suggesting that those individuals whose siblings visited frequently were less lonely. Even though this study found the frequency of sibling contact to be significant in relation to loneliness, the loss of an attachment figure which can lead to an emotional loneliness remains a better predictor of loneliness than social isolation overall (Weiss, 1974; Dugan & Kivett, 1994).

In summary, the bereavement literature identifies the loss of an attachment figure from one's life as an experience that can lead to feelings of loneliness. The support of family members during bereavement does not necessarily guarantee that one will not experience loneliness. The older the widow is, the more important the social support from friends becomes in protecting her from loneliness (Lopata et al., 1982). Therefore social support functions differently for widows of different ages.

Loneliness and The Dimensions of Health

Research has shown that loneliness may be an important etiological
component in the health of a variety of populations throughout the lifecycle (Kiecolt-Glaser, Garner, Speicher, Penn, Holliday, & Glaser, 1984a; Kiecolt-Glaser et al., 1984b). These studies found that those individuals who reported more loneliness also demonstrated decreased immunologic functioning when serum levels were tested. These studies utilized medical students in their samples and not elderly widows.

Research with elderly populations has also demonstrated a positive and strong association between reports of loneliness and poorer physical and mental health (Tunstall, 1968; Kivett, 1979; Berg, Mellstrom, Persson, & Svanborg, 1981; Baum, 1982; Lee & Ishii-Kuntz, 1988; Kaufman & Adams, 1988; Creecy, Berg, and Wright, 1985; Austin, 1989; Shearer & Davidhizar, 1993; Russell, 1996; Martikainen & Valkonen, 1996). Few studies were found that examined the relationship between loneliness and health in a widowed elderly population. When there were studies examining the health of older widows they tended to focus on the relationship between depression and health rather than loneliness (Gallagher, Breckenridge, Thompson & Peterson, 1983; Stroebe & Stroebe, 1994).

As mentioned earlier, the studies that examined the relationship between loneliness and health in widowed populations are less plentiful (Lichtenstein,
Gatz, Pedersen, Berg, & McClearn, 1996; Gfellner & Finlayson, 1988; Scott & Kivett, 1985; Lopata, 1993) and do not always deal with an elderly population of widows (Lichtenstein et al., 1996).

Lopata's work with American widows (1979) suggested that loneliness is one of the most challenging problems in widowhood that can lead to poor health. Similar to the work of Weiss (1975), Lopata found that many of the widows suffered from an emotional loneliness after the loss of their husband that was not lessened by the support of family and friends. Other studies found that married older persons score lower on distress (Thompson et al., 1989); depression (Lund, Caserta, & Dimond, 1989); loneliness (Creecy, Berg, & Wright, 1985) and report better health and well-being (Gallagher-Thompson, Futterman, Farberow, Thompson, & Peterson, 1993; Lund, Caserta, & Dimond, 1993; Stroebe and Stroebe, 1993) than do widows and widowers. In a study using a random sample of \( n=30; \bar{x}=75.2 \) years) widows from an older adult community, Gfellner and Finlayson (1988) reported that loneliness in widows was inversely related to psychological well-being \( (r=-.46, p<.05) \). Those widows with higher loneliness scores had poorer psychological well-being. Although there was strength in the random sampling procedure, the sample was small thus limiting the generalizability of the results.
In contrast to some of the above studies, Adlersberg and Thorne (1990) found that widowhood was not associated with poor health, loneliness and decreased subjective well-being. Widows in this study found the transition from wife to widow an emancipating experience, allowing them an introduction to freedom that they had never experienced before.

In a longitudinal study examining the impact of psychosocial factors on health in the elderly (n=301, \( \bar{X} = 65 \text{yrs} \)), Russell (1996), reported that although correlations were weaker, loneliness was found to be significantly related to health status \( (r = -0.18; p<.01) \) and number of chronic illnesses among the elderly.

The studies reviewed suggest that those elderly who reported more loneliness, were also found to suffer from poorer health. The majority of these studies were conducted with elderly samples who were not necessarily widowed or North American (Berg et al., 1981).

**Limitations of the Studies Reviewed**

The trend in social support literature in the past decade has been to view social support as a multidimensional concept other than a unidimensional construct. There still remains however, little agreement regarding the definition of social support. This continues to make comparison of studies extremely difficult. Weiss's Typology of Relational Provisions, although not new (1974),
has been helpful, through the identification of the six social provisions: (attachment, social integration, nurturance, reassurance of worth, reliable alliance, and guidance); in understanding some of the problems individuals may encounter (i.e. loneliness, decreased social support) when a social provision like attachment/intimacy or reliable alliance is perceived as lacking by an individual. The literature has also demonstrated a strong case for the beneficial effects of social support in relation to health outcomes. With the exception of three studies (Buunk & Hoorens, 1992; Tilden & Galyen, 1987; Rook, 1984) which identify some of the negative effects of social support, the results across studies are consistent, and demonstrate that social support has positive outcomes for the individuals who receive it.

Social support has been studied in various populations including college students (Lakey et al., 1996), and the younger elderly with mean ages ranging from 66 to 67.6 years (Lund et al., 1990; Warner, 1987; Dimond et al., 1987). No studies were found that sampled exclusively the older widow, thus making generalizability of the findings to this group challenging.

The majority of the studies that examined the variables of social support, health, and loneliness in widowhood were conducted with samples in the United States, Sweden (Lichenstein et al., 1996), Japan (Sugisawa et al., 1994), and the
Netherlands (Stroebe et al., 1983; Stroebe et al., 1993) with the exception of Gfellner and Finlayson (1988) which was a Canadian study. While Canadian research in this area continues to grow, in comparison, it is still relatively small (Martin-Matthews, 1991).

The sample sizes in some of the studies examined were small, making the generalizability of the findings difficult. Investigators in bereavement research have cited problems in recruiting the appropriate sample size for their studies. Individuals dealing with the loss of a loved one face many challenges. Dealing with these challenges requires time and energy, thus many potential participants either drop out of a study or refuse to participate in the first place because of the limited time and energy they possess (Dimond, Lund, & Caserta, 1987).

Another limitation in the bereavement literature examining social support, health, and loneliness was the design of the studies. Although many of the studies used either cross-sectional or longitudinal designs, some studies did not obtain comparable prewidowhood data for variables such as health, and/or did not have the appropriate age matched comparison group (Stroebe & Stroebe, 1993; Stroebe & Stroebe, 1983).

Summary of the Literature Review

The studies examined indicate that the loss of a spouse is one of the most
challenging life events one can experience. The loss of an attachment figure can lead to an emotional loneliness (Weiss, 1973) which can lead to increased physical illness, and poorer mental health for the bereaved elderly. Those who believe they have a strong support system can make the adaptation to the role of widow in better physical and mental health than those individuals who do not have strong support systems. Many studies examining social support and health in elderly populations have examined the relationship these variables have to depression. Studies on loneliness have used primarily younger samples.

In summary, although the literature reviewed has addressed social support, health, and loneliness in both widowed and elderly samples, no study examined the relationship between the perceived provisions of social support, the dimensions of physical, mental, and social health, and loneliness in a population of widowed elderly women ($\bar{x}$ age = 72 years) in Canada. This study will examine the perceived provisions of social support, the dimensions of physical, mental, and social health, and loneliness in a sample of Canadian widowed elderly women.
**Conceptual Framework**

The conceptual framework for this study is predicated upon attachment theory (Bowlby, 1969; Weiss, 1975, 1982) and the proposition that the loss of one’s spouse is a challenging life event which can affect both physical and mental health and lead to loneliness. The conceptual framework is comprised of three main concepts: the perceived provisions of social support; the dimensions of self-rated health, and loneliness.

In attachment theory, the idea that supportive friends can compensate for the loss of an attachment figure is not accepted (Bowlby, 1969; Weiss, 1974, 1982). This theory argues that the attachment figure can uniquely nurture feelings of security and comfort in the recipient, and that no one else in the individual’s life can resume this function after the loss of the attachment figure. It goes on to argue that there are different types of social support that are required by the individual depending on the characteristics of the challenging event they are experiencing (Bowlby, 1969; Weiss, 1974, 1982).

The loss of one’s spouse and the adjustment required to a life without one’s marital partner can contribute to poorer health and a feeling of loneliness (Ferraro, 1989). The perception that one has or does not have the support of
family and friends may impact on how the elderly widow rates her health and lead to a feeling of loneliness.

The conceptualization of both social support and loneliness in the literature is varied. There is however, consistency in the literature regarding the lack of consensus around a clear definition of both social support and loneliness. The definition of social support and loneliness used for this investigation is based on Weiss’s Typology of Relational Provisions (Weiss, 1974), which include the provisions of: (a) attachment (provided by relationships that provide safety and security); (b) social integration (provided by relationships where interests and concerns are shared); (c) opportunity for nurturance (provided by relationships where the person feels responsible for the well-being of another person); (d) reassurance of worth (provided by relationships in which the person’s skills and abilities are admired); (e) a sense of reliable alliance (provided by relationships where the person can rely on assistance under any circumstances); and (f) the obtaining of guidance (provided by relationships with trustworthy individuals who can provide advice and assistance). A perception of a deficit in two or more of the above provisions of support can lead to both an emotional and/or social loneliness (Weiss, 1974).
The feeling that one is not receiving one or two of the provisions of social support and the resulting emotional and/or social loneliness that may occur. can also lead to a feeling of poorer health. The conceptualization of health for this investigation includes eight dimensions as identified by Ware et al. (1997). The eight dimensions of health include: physical functioning; role limitations related to physical health; bodily pain; general health; vitality; social functioning; role limitations related to emotional health; mental health; and a reported health transition (an unscored change is assessment of health status).

The loss of an important attachment relationship (spouse) and the perception that one does not have the support one needs to make the adjustment (widowhood) can lead to a feeling of emotional loneliness and lesser health. These relationships will be explored in this investigation.

**Research Questions**

This investigation addressed the following questions:

1) What is the relationship between the perceived provisions of social support and the physical, mental, and social dimensions of self-reported health in elderly widows?

2) What is the relationship between the perceived provisions of social support and loneliness in elderly widows?
3) What is the relationship between loneliness and the physical, mental, and social dimensions of self-reported health in elderly widows?

**Definition of Terms**

The Provisions of Social Support - Social support is defined as the provision of:
- attachment (emotional closeness or intimacy giving one a sense of security);
- social integration (a sense of belonging to a group that shares similar interests);
- opportunity for nurturant behaviour (the sense that others rely upon one for their well-being);
- reassurance of worth (recognition of skills and accomplishments);
- a sense of reliable alliance (i.e. availability of emotional, informational, and tangible assistance); and
- the obtaining of guidance (advice or information).

(Weiss, 1974). This investigation will examine the perceived provisions of social support and it will be measured using the Social Provisions Scale (Russell & Cutrona, 1987).

Loneliness - Loneliness is the response to the absence of one or more needed relationships or the absence of a particular relational provision (Weiss, 1974). Social loneliness may exist when one does not belong to a group or social network. Emotional loneliness is the response to the absence of the relational provision of attachment/intimacy (Weiss, 1974). Loneliness will be measured by the UCLA Loneliness Scale (Version 3) (Russell, 1996).
Health - A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization. Ware, Snow, Kosinski, & Gandek. 1997). The dimensions of self-reported health will be measured with the Health Status Profile - Short Form (SF-36), (Ware et al., 1997).

Dimensions of Self-Reported Health - The eight dimensions of self-reported health measured by the SF-36, are defined as follows: a) Physical Functioning (the ability to perform all types of physical activities including the most vigorous); b) Limitations in Role Function related to Physical Health (the ability to perform work or other daily activities with no interference as a result of physical health); c) Bodily Pain (no complaints of pain or limitations due to pain); d) General Health (the evaluation of personal health); e) Vitality (the feeling of pep and energy); f) Social Functioning (the ability to perform normal social activities); g) Limitations in Role Function related to Emotional Health (the ability to perform work or other daily activities with no interference as a result of emotional problems); h) Mental Health (a feeling of peacefullness, happiness, and calm). (Ware et al., 1997).
Chapter II

Methods and Design

Design

In this study, a descriptive correlational design was used to describe and examine the relationships among the provisions of social support, loneliness, and the dimensions of health, in a sample of elderly women who had lost a spouse. This design permitted the collection of data at one point in time from a sample of elderly widows, and the examination of relationships among the three concepts. (Burns & Grove, 1997).

Setting

Participants in this study were recruited from two community hospices located in a Metropolitan area in Southern Ontario.

One of the hospices provides a number of services to families who have suffered the loss of a loved one. Services provided include: one-on-one home visits; telephone support; and some weekly group support meetings held at the hospice. Services are delivered by volunteers from the community. The hospice was started in 1989 and saw approximately 200 clients last year. Individuals 60 years and over make up approximately two thirds of the caseload (Martin, Personal Communication, 1997).
The other hospice, founded in 1983, also provides in-home and telephone support to individuals and families dealing with death and dying. Trained volunteers offer emotional and practical support, as well as respite care to their clients, which include children, adults, and the elderly. An eight week Grief and Bereavement Program that runs several times yearly by trained facilitators, offers adults and children the opportunity to discuss issues around loss. Workshops and seminars on palliative care are conducted both onsite and in the community. The Hospice library provides clients with resources on palliative care and bereavement (Seidler, Personal Communication, 1997; Information Sheet, 1997).

Sample

The target population for this study were elderly widows who had experienced the loss of their spouses between six months to two years. Individuals experiencing conjugal bereavement for less than six months would be considered too vulnerable to participate in a research study (Martin, Personal Communication, 1997; Anderson & Dimond, 1995), and those individuals widowed for more than two years may have developed coping mechanisms to deal with their new situation (Martin, Personal Communication, 1997).

In addition to recruiting participants from the two community hospices, participants were also recruited through the strategy of network sampling. An
individual widow who met the inclusion criteria was identified and asked for her assistance in contacting another widow who met the inclusion criteria. A referral was then made to the investigator after the potential participant had been contacted by the widow who made the referral and had demonstrated interest in the study. Often referred to as "snowballing", this process continued until a sample of 30 widows was obtained (Burns & Grove, 1997). Snowballing or network sampling is a useful strategy for locating samples that may otherwise be difficult to obtain (Burns & Grove, 1997). The majority of the sample were recruited from the two hospices (n=23), with less than one third recruited through network sampling (n=7).

**Inclusion Criteria**

The criteria for inclusion in this study were: 1) Able to speak and read English. 2) 60 years of age or older, and 3) Widowed between 6 months and 2 years.

**Exclusion Criteria**

Widows with altered or impaired cognitive status as identified by the staff at the two community hospices, and as identified by the widows in the social network (network sampling) after being advised of the exclusion criteria. The
reason for excluding them related to the difficulty they would have encountered completing the questionnaires.

**Instruments**

In this investigation, the instruments used included: 1) a Demographic Data Sheet, to collect demographic data (Developed by investigator. 1997), (Appendix A). 2) The Social Provisions Scale, to measure the perceived provisions of social support (Russell and Cutrona, 1987); (Appendix B). 3) The Health Status Profile -SF-36, to measure the dimensions of self-rated health status (Medical Outcomes Trust, 1996), (Appendix C), and 4) The University of California (Los Angeles) Loneliness Scale (UCLA) Version 3, to measure loneliness (Russell, 1996). (Appendix D).

**Demographic Data Sheet**

A demographic data sheet (DDS) designed by the investigator, was used to collect information regarding the subject’s personal background. This data sheet was comprised of seven items and included personal background information such as the participant’s age, employment status, level of education, annual income, number of years married, length of time widowed, and number of dependants. The demographic data sheet was comprised of a series of close-ended questions with a specific list of responses from which to select.
Social Provisions Scale

The Social Provisions Scale developed by a research group at UCLA (Russell & Cutrona, 1987) was used to measure perceived social support. It consisted of 24 items with a four point Likert Scale ranging from "strongly disagree" to "strongly agree".

The Social Provisions Scale is based on Weiss’s (1974) model of social provisions. Therefore, the scale measured the six social functions or provisions that can be experienced from relationships with others: guidance (information or advice: items 3, 12, 16, and 19); reliable alliance (the assurance that someone can be depended on for tangible support; items 1, 10, 18, 23); reassurance of worth (recognition of one’s value, skills, and competence by others; items 6, 9, 13, 20); opportunity for nurturance (the sense that others rely on one for their well-being; items 4, 7, 15, 24); attachment (emotional closeness giving one a sense of security; items 2, 11, 17, 21); and social integration (a sense of belonging to a group; items 5, 8, 14, 22). (Weiss, 1974). (Appendix B).

A total score for each type of social provision was computed as the mean of the scores of the items comprising it. A high score indicated that the individual was receiving that provision. Negatively stated items (2, 3, 6, 9, 10, 14, 15, 18, 19, 21, 22, 24) were reverse coded before scoring (Russell and Cutrona, 1987).
The reliability of the Social Provisions Scale was evaluated in a sample of 783 college students (Russell & Cutrona, 1987), and 303 teachers (Russell, Altmaier, & Velzen, 1987). The coefficient alphas for the six provisions (subscales) ranged from .65 to .76 (Russell & Cutrona, 1987), thus demonstrating its reliability.

The construct validity of the Social Provisions Scale was determined in a sample of 242 college students. The correlations between scores on the Social Provisions Scale and scores on other measures of social support (Social Support Questionnaire, the Index of Socially Supportive Behaviours, a measure of attitudes towards the use of social support), as well as scores on related concepts such as social desirability, depression, introversion-extroversion, neuroticism, and number of stressful events supported the validity of the scale. The correlation coefficients for the support measures ranged from .350 to .458 (p<.001). The correlation coefficients for the variables of depression and introversion-extroversion ranged from -.278 to .289 (p<.001); social desirability .124 (p<.05) and neuroticism -.199 (p<.01). The correlations between the scores on the Social Provisions Scale and other support measures were higher, thus lending support for the construct validity of the Social Provisions Scale.
The Health Status Profile - SF-36

The SF-36 is a self administered questionnaire, multidimensional measure of health covering physical functioning (items 3a-3j); social functioning (items 6,10); role limitations due to physical problems (items 4a-4d); role limitations due to emotional problems (items 5a-5c); pain (items 7, 8); vitality (items 9a, 9e, 9g, 9i); mental health (items 9b, 9c, 9d, 9f, 9h); general health perceptions (items 1, 11a, 11b, 11c, 11d); and one unscored assessment of change in health status (item 2) taking less than 10 minutes to complete (Hayes, Morris, Wolfe, & Morgan, 1995). (Appendix C). It was developed for use in the Medical Outcomes Study (tested in over 22,000 patients) in the United States by Ware and colleagues (Lyons, Perry, & Littlepage, 1994).

The Health Status Profile SF-36 questionnaire has a Likert type scale. The values from the items comprising each subscale (where the subscales reflect the 8 dimensions of health), were summed and transformed into a score out of 100 which provided a single subscale score for each subject. Higher scores indicated higher levels of health.

The reliability of the SF-36 scale and its subscales was evaluated in the Medical Outcomes Study (McHorney, Ware, Lu, & Sherbourne, 1994). Patients, (n=3,445) representing 24 subgroups differing in age, education, economic
situation, diagnosis, and severity of disease were included in the study sample. Internal consistency reliability coefficients for the eight subscales in the SF-36 from the above study varied between 0.82 for the mental health subscale to 0.94 for the physical functioning and role limitations due to emotional problems subscales. The internal consistency reliability of the subscales was demonstrated in other studies, using different patient subgroups (McHorney et al., 1994).

In a study (n=216, 65 yr and older), the Health Status Profile SF-36 was found by Lyons, Perry, and Littlepage (1994) to be an appropriate questionnaire for use in an elderly population in an interview setting. Cronbach’s alpha coefficients ranged from 0.82 for the subscale of mental health to 0.94 for the subscale of physical functioning, thus demonstrating adequate internal consistency in this population.

The construct validity of the Health Status Profile SF-36 was tested in the above study (Lyons, Perry, & Littlepage, 1994), by comparing the eight subscales in the groups of elderly persons whose health status was expected to differ (i.e. those who suffered from an ongoing disability, had visited their doctor in the past two weeks, or were hospital inpatient/outpatients in the past 12 months). The SF-36 was able to distinguish clearly between those elderly individuals with and without a long standing disability thus adding strength to the validity of the
instrument (Lyons et al., 1994). The study suggests that the SF-36 is indeed appropriate for use in an elderly population.

**The University of California (L.A.) Loneliness Scale Version 3**

The UCLA Loneliness Scale Version 3 is a self-administered, 20 item questionnaire. It contains eleven negatively worded statements which are descriptive of feelings of loneliness and nine positively worded statements which are descriptive of feelings of non-loneliness or satisfaction with social relationships. Each item begins with "How often do you feel..." in order to simplify its use through telephone use or personal interviews (Russell, 1996). A Likert-type response format that included frequency responses such as never, rarely, sometimes, and always, was used. The nine positively worded items which include numbers 1, 5, 6, 9, 10, 15, 16, 19, and 20 were reverse coded for scoring purposes (i.e. 4=1) and the final scores for each subscale were summed together. Higher total scores indicated greater degrees of loneliness (Russell, 1996).

In studies of college students (n=489); nurses (n=310); teachers (n=316); and the elderly 65 years old and over (n=301), the UCLA Loneliness Scale demonstrated high reliability with coefficient alphas ranging from .89 to.94 across the samples (Russell, 1996). The scale was readministered one year later to the
elderly sample with a test-retest correlation of .73. The UCLA Loneliness Scale Version 3 continues to be highly reliable.

In the studies completed by Constable and Russell (1986) with the sample of nurses (n=280) and Russell et al. (1987) with a sample of teachers (n=307), loneliness was positively related to burnout (r=.45, p<.001) for both samples. Statistically significant negative correlations were found between all measures of social support and loneliness scores as well. For the nurses, the negative correlations ranged from -.19 for social support from supervisors to -.33 for social support from co-workers (p<.001), while for the teachers, the correlations were -.23 and -.43 (p<.001) respectively. These correlations provide empirical evidence supporting the construct validity of the UCLA Loneliness Scale.

In the study with the elderly (n=301), perceived quality of a person’s relationships measured with the Social Provisions Scale, was correlated with loneliness (r=-.54, p<.01) (Russell, 1996). Version 3 of the UCLA Loneliness Scale is a valid and reliable instrument that can be used in diverse populations (Russell, 1996).

Data Collection Procedures

After obtaining approval from the Human Subjects Review Committee at the University of Toronto, a meeting with the executive directors of the two
hospices was arranged to explain the purpose of the study and the inclusion/exclusion criteria for the study. Hospice staff felt that it was in the best interest of their clients if they both introduced the study, and made a follow up call to the client to obtain permission to pass their phone number to the investigator, if they were interested in learning more about the study. Following the meeting, a letter introducing the investigator, and explaining the purpose of the study, was sent to those individuals that had participated in the bereavement support programs at each of the above sites and met the inclusion/exclusion criteria as identified by the executive directors (Appendix E). Hospice staff from both sites made follow up calls to those who had received a letter. The names and phone numbers of individuals wanting to learn more about the study were passed on to the investigator by the staff. These individuals were contacted by the investigator to discuss the study and set up a time and place to meet (Appendix F). A letter introducing the investigator, and explaining the purpose of the study was also sent to those individuals identified through the use of network sampling. A follow up call was made by the investigator to discuss the study and arrange a time and place to meet as well. The majority of interviews were conducted in the widows’ homes, with one taking place in a coffee shop at the request of the individual. The participants were asked to read and sign the consent forms before
the interviews began (Appendix G). The interviews consisted of administering all the instruments to collect data on social support, loneliness, and health. Any further questions about the study that the individual participant had were answered by the investigator at this time. The interviews took 20-30 minutes to complete. After each interview was completed, the investigator took all the completed instruments and locked them in a filing cabinet.

Data Analysis Plan

In this investigation descriptive statistics (measures of central tendency and dispersion) were used to describe the sample. Pearson’s Correlation Coefficients were computed between the variables of the perceived provisions of social support and the dimensions of self-rated health, the perceived provisions of social support and loneliness, and loneliness and the dimensions of self-rated health in order to examine the relationships between these variables (Burns & Grove, 1997).

Plan for Protection of Participants’ Rights

Procedure for Obtaining Access to Participants

The elderly are a particularly vulnerable population, and great care must be undertaken to ensure that each participant in the research process is competent to
render a freely informed consent to participate in research. Respect for the autonomy of the elderly participant is crucial.

In this study, after permission was obtained from the Office of Research Services at the University of Toronto for ethical review to conduct the study, and the executive directors of the two hospices had given the investigator permission to access the clients from their organizations, the process of obtaining a non-probability convenience sample was begun. The strategy of network sampling assisted in ensuring that the desired sample size was obtained. Potential participants were sent a letter that informed them of the purpose of the study, the expectations, and the time commitment (20-30 minutes) involved for participation. Follow-up phone calls were made by the investigator within two weeks of mailing the letter to see if they would like any additional information about the study. If the potential participants agreed to participate, a time and place for the interviews to take place was arranged.

**Informed Consent**

Potential participants were informed that should they agree to participate in this investigation, they would be under no obligation to complete the study or answer all the questions, and would be free to withdraw from the study at any time with no explanation required. A written consent (Appendix G), explaining the
nature and purpose of the study was obtained from each participant by the investigator prior to the commencement of the interview.

Confidentiality

The investigator explained to the participants that in order to ensure confidentiality during the study, a code number would be assigned to each participant. The list of names and corresponding code numbers of participants were locked in a filing cabinet to preserve confidentiality. The investigator and her thesis supervisor are the only people who have access to the filing cabinet. Participants were reassured that only the assigned code numbers would appear on the questionnaires.

Risks and Benefits

Although there were no anticipated risks for those who volunteered to participate in this study, the investigator acknowledged the potential vulnerability of those who have lost a spouse. During the interview process, if a question triggered an emotional response from a participant, the investigator followed the request of the participant to either terminate the interview and reschedule, or continue with the interview. Two of the women became teary eyed during the interview, but instructed the investigator to continue with the interview. The investigator was prepared to make a referral for follow-up counselling services
had this been requested by the participants. No requests for counseling were made.

Volunteers understood that although they might not incur direct benefits as an individual from participating in the study, the results from this investigation would contribute to a larger knowledge base that would assist others dealing with the challenges of conjugal bereavement.
Chapter III

Results

The results of the data analyses are reported as follows: a) response rate, b) characteristics of the sample, c) frequencies of the major variables, d) results related to each research question, and e) summary of results.

Response Rate

A total of forty women were approached for the study. Of the forty women, 30 completed the questionnaires, with a response rate of 75%. Of the ten respondents who declined to participate: a) two cited illness as the reason and felt that they were too weak to participate, b) two were embarking on lengthy vacations, c) one felt that she was coping well since her husband’s death and did not have the time to participate in a study and d) the other five explained that they were not interested in participating.

Characteristics of the Sample

The sample consisted of 30 women living in a Metropolitan city in Southern Ontario. The average age of the women was 71.6 years (SD = 5.8, range = 60-82). The majority of the sample were recruited from two hospices (n=23), with less than one third (n=7) recruited from the process of network sampling.
The majority (n=28, 93%) saw their doctor for regular check-ups. A couple of the women (n=2, 7%) felt that it was unnecessary to visit their doctor regularly, unless they were ill.

The majority of women (n=19, 63%) were either retired, or considered themselves full-time homemakers (37%). The women were well educated, with over half of the sample (n=16, 53%) having completed high school and seven (23%) having obtained a college diploma (Table 1).

The income of the sample varied. Nearly half (n=14, 47%) of the women had a yearly income of between $10,000 to $30,000 with four (13%) having incomes in excess of $50,000 (Table 1). Five women (17%) did not respond to this question, because they were involved in sorting out financial issues, and were not sure what their yearly income was.

Over half (n=16, 53%) of the women had been married between 40-50 years (Table 2). The average number of months widowed was 13.7 months (SD=5.5, range = 6-24). The majority (80%) had been widowed in the range of 6-18 months (Table 2). About 53.3% of the women were widowed for less than or equal to one year, and 46.6% were widowed for more than one year. Twenty-nine (97%) of the women had children.
Table 1 - **Frequencies and Percentages for Education, Employment, and Income**

(n=30)

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*Note.* The total percentage may not equal 100 due to roundoff error.
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*Note.* The total percentage may not equal 100 due to roundoff error.
The Frequency of Major Variables

The Perceived Provisions of Social Support

The perceived provisions of social support was measured with the Social Provisions Scale (Cutrona & Russell, 1987). The scale reflects six social functions or provisions that can be experienced from relationships with others. A total score was computed for each social provision, after reverse coding the negatively stated items, so that higher scores indicate that the respondents are receiving that provision.

The scores on guidance ranged between 2.50 and 4.00, with a mean of 3.15 (SD=.35). The majority (87%) of the women scored between 3.00 and 4.00 for guidance, thus suggesting that they believed they were receiving advice and information from their support system. The average score on reassurance of worth was 2.99 (SD=.35, range = 2.50 to 4.00). Sixty-three percent scored between 3.00 and 4.00 for reassurance of worth indicating that the majority felt that their competence and skills were valued by others. The scores on social integration also ranged between 2.50 and 4.00, with a mean of 3.07 (SD=.30). The majority (83%) scored between 3.00 and 4.00 suggesting that these women felt a sense of belonging to a group that shared similar interests to themselves. The provision of attachment had an average score of 3.23 (SD=.31, range =2.75 to 4.00). Eighty-
three percent of the women scored between 3.00 and 4.00. This suggests that these women felt they had an emotional closeness with someone in their support system that gave them a sense of security. The scores on nurturance ranged between 1.75 and 3.50, with a mean of 2.70 (SD=.50). In this provision, less than half of the women (40%) had scores between 3.00 and 4.00. The majority did not feel that they were responsible for the well-being of another person. Finally, the average score on alliance was 3.34 (SD=.27, range=2.75 to 4.00). The majority (97%) of the women felt that they had other people in their support system that they could call upon for tangible assistance.

**The Dimensions of Self-Reported Health**

The dimensions of self-reported health was measured with the SF-36. The SF-36 measures eight dimensions of health including: physical functioning; social functioning; role limitations due to physical problems; role limitations due to emotional problems; pain; vitality; mental health; and general health perceptions. Assessment of change of health status in the past year was also measured. Higher scores on the SF-36 subscales reflect increased functioning or a higher level of health. Scores for each dimension of health were computed using the following formula from the SF-36 Health Survey Manual and Interpretation Guide (Ware, Snow, Kosinski, & Gandek, 1997).
Transformed Scale Score = \( (\text{Actual raw score} - \text{lowest possible raw score}) \times 100 \)
\[ \frac{\text{Possible raw score range}}{20} \]

Each raw scale score was transformed to a 0 to 100 scale using this formula and information provided in the scoring manual. Thus, for example, a raw score of 19 for physical functioning would be transformed to

\[ \frac{(19-10)}{20} \times 100 = 45. \]

where the lowest possible score = 10, and the possible raw score range = 20

(Medical Outcomes Trust, 1997, p. 20). The results reported below concern the transformed scores.

The scores obtained from the thirty women on physical functioning ranged between 10 and 100, with a mean of 72.33 (SD=22.88). In this dimension, (53%) scored between 80 and 100, indicating that the majority of women felt that they could perform a variety of physical activities without limitations. The average score on role limitations due to physical problems was 65.00 (SD= 41.31, range 0 to 100). In this dimension, there were only five possible scores (0, 25, 50, 75, 100). (Appendix C). Sixty-three percent of the women scored either 75 or 100, suggesting that they believed they had no problems with work or other activities as a result of physical health. The scores for bodily pain ranged between 0 and 100 with a mean of 63.43 (SD=29.22). Over one quarter (27%) of the women scored 100, indicating that they had no pain or limitations due to pain. One third (33%) scored between 51 and 61 reporting
that they had some pain. One woman did not answer this question and scored 0.

The general health dimension had an average score of 69.89 (SD= 21.41, range = 25.00 to 100.00). The majority (60.2%) of the women scored between 67 and 100 indicating that the women perceived their health as good or excellent. The scores for the vitality dimension ranged between 0 and 95.00, with a mean of 57.33 (SD=22.92). Sixty percent scored between 55 and 95, reporting that they had pep and energy. Social functioning scores ranged from 12.50 to 100.00, with a mean of 75.83 (SD=29.89). Fifty percent scored 100, indicating that they maintained their social activities. The average score of the dimension of role limitations due to emotional problems was 53.33 (SD=44.29, range = .00 to 100.00). In this dimension, there were four possible scores (0, 33.33, 66.67, or 100). Forty-three percent scored 100 indicating no problems with work or other activities due to emotional health. Only (n=9, 30%) had a score of 0, thus reporting some difficulty with daily activities due to emotional health. Finally, the last dimension of mental health, had scores ranging between 12.00 and 96.00, with a mean of 68.93 (SD=20.22). Four women (13.3%) scored between 12 and 40, with half (50%) scoring between 72 and 96. Thus, the majority of women reported feeling peaceful, happy, and calm most of time to all of the time.
For the Reported Health Transition item (2), (Appendix C), Ware et al. (1997) recommends that the responses be treated as ordinal level data, and that the percentage of respondents who selected each response choice be analyzed. Therefore, when asked how they would compare their health now, to one year ago, four women (13.3%) answered “much better”, with three (10.0%) reporting that their health was “somewhat better”. The majority (n=18, 60%), felt that their health had remained “about the same”. Four women (13.3%) felt that their health was “somewhat worse”, with one (3.3%) reporting that her health was “much worse” compared to one year ago.

**Loneliness**

The UCLA Loneliness Scale Version 3, a 20 item questionnaire, was used in this investigation to measure loneliness. Total scale scores were computed after reverse coding the positively stated items, so that higher total scores indicate a greater degree of loneliness. The scores for the thirty women varied between 1.20 and 2.70, with a mean of 1.81 (SD=.431). Over half of the women (n=18, 60%) scored between 1.20 and 1.95. These scores suggests that overall these women were reporting that they were never to rarely lonely. The remaining forty percent of the women scored between 2.05 and 2.70, thus reporting they were
rarely lonely. Only one woman (3.3%) scored 2.70, thus reporting that she was sometimes lonely.

Results Related to Research Questions

In this investigation, Pearson’s Product-Moment Correlation Coefficients were computed between the variables of the perceived provisions of social support and the dimensions of self-rated health, the perceived provisions of social support and loneliness, and the dimensions of self-rated health and loneliness in order to examine the relationships between these variables addressed in the study research questions.

Research Question 1: What is the relationship between the perceived provisions of social support and the dimensions of self-reported health in elderly widows?

The relationships between the different subscales for the perceived provisions of social support and the dimensions of self-reported health were examined. See Table 3 for the correlation matrix demonstrating these relationships. Statistically significant correlations were found between the subscales of the perceived provisions of social support and those of the dimensions of self-rated health. Guidance correlated positively with physical functioning \((r=0.37)\), role limitations due to physical problems \((r=0.46)\), general
health \((r=.49)\), vitality \((r=.61)\), social functioning \((r=.38)\), and mental health \((r=.56)\) (Table 3). Therefore, those who felt they were receiving information and advice also reported: few to no limitations in physical activity due to health; few to no problems with work or other daily activities as a result of physical health; their health as good or excellent; feeling full of pep and energy almost all of the time; being able to perform their social activities without interference from physical or emotional problems; feeling peaceful, happy, and calm most of the time. Reassurance of worth had positive correlations with physical functioning \((r=.45)\), role limitations due to physical problems \((r=.42)\), general health \((r=.43)\), and vitality \((r=.42)\) (Table 3). Those who believed others recognized their competence and skill reported: few to no limitations in physical activity due to health; few to no problems with work or other daily activities as a result of physical health; their health as good to excellent; feeling full of pep and energy most of the time. Social integration correlated positively with bodily pain \((r=.42)\), general health \((r=.57)\), vitality \((r=.54)\), social functioning \((r=.48)\), role limitations due to emotional problems \((r=.39)\), and mental health \((r=.40)\). Therefore, those who felt that they belonged to a group who shared their interests, also reported: few or no limitations due to pain; their health as good to excellent; feeling full of pep and energy almost all of the time; being able to perform their social activities
without interference from physical or emotional problems; few to no problems with work or other activities as a result of emotional problems; feeling peaceful, happy, and calm most of the time. Attachment correlated positively with general health \( (r=0.40) \) and role limitations due to emotional problems \( (r=0.40) \). That is, those who felt they had an emotional closeness with someone reported their health as good to excellent and reported few to no problems with work or daily activities in relation to emotional health.

Statistically significant relationships were also found between the subscales of the perceived provisions of social support and the reported health transition item (Table 4). Guidance and worth correlated negatively with the reported health transition item \( (r=-0.56) \) and \( (r=-0.60) \) respectively. Therefore, those who felt they were receiving appropriate information and advice, and felt respected for their competence reported that their health was much better now than one year ago.
Table 3 Correlation Matrix for the Perceived Provisions of Social Support and The Dimensions of Self-Reported Health (n=29).

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Guidance</td>
<td>.37 (p=.044)</td>
<td>.46 (p=.011)</td>
<td>.27 (p=.156)</td>
<td>.49 (p=.006)</td>
<td>.61 (p=.000)</td>
<td>.38 (p=.038)</td>
<td>.35 (p=.062)</td>
<td>.56 (p=.002)</td>
</tr>
<tr>
<td>Worth</td>
<td>.45 (p=.014)</td>
<td>.42 (p=.021)</td>
<td>.30 (p=.103)</td>
<td>.43 (p=.020)</td>
<td>.42 (p=.022)</td>
<td>.28 (p=.140)</td>
<td>.27 (p=.149)</td>
<td>.26 (p=.171)</td>
</tr>
<tr>
<td>Social Integration</td>
<td>.15 (p=.430)</td>
<td>.33 (p=.074)</td>
<td>.42 (p=.022)</td>
<td>.57 (p=.001)</td>
<td>.54 (p=.002)</td>
<td>.48 (p=.008)</td>
<td>.39 (p=.034)</td>
<td>.40 (p=.030)</td>
</tr>
<tr>
<td>Attachment</td>
<td>.18 (p=.331)</td>
<td>.22 (p=.251)</td>
<td>.23 (p=.213)</td>
<td>.40 (p=.029)</td>
<td>.30 (p=.106)</td>
<td>.32 (p=.086)</td>
<td>.40 (p=.031)</td>
<td>.33 (p=.074)</td>
</tr>
<tr>
<td>Nurturance</td>
<td>-.07 (p=.712)</td>
<td>-.22 (p=.244)</td>
<td>-.23 (p=.223)</td>
<td>-.03 (p=.849)</td>
<td>-.07 (p=.717)</td>
<td>.08 (p=.654)</td>
<td>-.04 (p=.797)</td>
<td>-.04 (p=.815)</td>
</tr>
<tr>
<td>Alliance</td>
<td>.18 (p=.336)</td>
<td>.30 (p=.111)</td>
<td>-.00 (p=.988)</td>
<td>.07 (p=.704)</td>
<td>.26 (p=.171)</td>
<td>.26 (p=.161)</td>
<td>.25 (p=.183)</td>
<td>.14 (p=.442)</td>
</tr>
</tbody>
</table>
Table 4  Correlations for the Perceived Provisions of Social Support and the Reported Health Transition (item 2) of the Dimensions of Self-Reported Health) (n=29)

<table>
<thead>
<tr>
<th>Perceived Provisions of Social Support</th>
<th>Reported Health Transition (Dimensions of Self-Reported Health)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidance</td>
<td>-0.56 (p=.001)</td>
</tr>
<tr>
<td>Worth</td>
<td>-0.60 (p=.001)</td>
</tr>
<tr>
<td>Social Integration</td>
<td>-0.25 (p=.183)</td>
</tr>
<tr>
<td>Attachment</td>
<td>-0.35 (p=.058)</td>
</tr>
<tr>
<td>Nurturance</td>
<td>-0.13 (p=.473)</td>
</tr>
<tr>
<td>Alliance</td>
<td>-0.07 (p=.696)</td>
</tr>
</tbody>
</table>
Research Question 2: What is the relationship between the perceived provisions of social support and loneliness in elderly widows?

The relationships between the perceived provisions of social support and loneliness was examined. The correlation coefficients are presented in Table 5. A negative but moderate correlation ($r = -.36$) was found between attachment and loneliness indicating that those who believed they had an emotional closeness with someone scored low on loneliness.

Table 5 Correlations for the Perceived Provisions of Social Support and Loneliness ($n=30$)

<table>
<thead>
<tr>
<th>Perceived Provisions of Social Support</th>
<th>Loneliness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidance</td>
<td>-.10</td>
</tr>
<tr>
<td></td>
<td>($p=.586)$</td>
</tr>
<tr>
<td>Worth</td>
<td>-.29</td>
</tr>
<tr>
<td></td>
<td>($p=.109$)</td>
</tr>
<tr>
<td>Social Integration</td>
<td>-.29</td>
</tr>
<tr>
<td></td>
<td>($p=.110$)</td>
</tr>
<tr>
<td>Attachment</td>
<td>-.36</td>
</tr>
<tr>
<td></td>
<td>($p=.048$)</td>
</tr>
<tr>
<td>Nurturance</td>
<td>.02</td>
</tr>
<tr>
<td></td>
<td>($p=.903$)</td>
</tr>
<tr>
<td>Alliance</td>
<td>-.03</td>
</tr>
<tr>
<td></td>
<td>($p=.868$)</td>
</tr>
</tbody>
</table>
Research Question 3: What is the relationship between loneliness and the dimensions of self-reported health in elderly widows?

The relationships between loneliness and each dimension of self-reported health were examined. The correlation coefficients are presented in Table 6.

Statistically significant relationships were found between loneliness and vitality (r = -.49), social functioning (r = -.50), role limitations due to emotional problems (r = -.39), and mental health (r = -.59). Thus, those women who reported feeling full of pep and energy most of the time, being able to perform social activities without interference from physical or emotional problems; few to no problems with work or other daily activities as a result of emotional problems; feeling peaceful, happy, and calm almost all of the time, also reported rare to no loneliness.

Table 6 - Correlations for Loneliness and the Dimensions of Self-Reported Health (n=30).

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Loneliness</td>
<td>-.16</td>
<td>-.27</td>
<td>-.26</td>
<td>-.30</td>
<td>-.49</td>
<td>-.50</td>
<td>-.39</td>
<td>-.59</td>
</tr>
</tbody>
</table>

Summary of Results

The purpose of this investigation was to examine the relationships among
the perceived provisions of social support, loneliness, and the dimensions of health in elderly widows aged 60 years and over. Pearson’s Product-Moment Correlation Coefficients (r) were used to examine these relationships.

Several statistically significant relationships were found between some of the perceived provisions of social support and some of the dimensions of self-reported health, implying that women who received different provisions of social support perceived high levels of health. The relationship between the perceived provisions of social support and loneliness yielded several negative relationships indicating that women perceiving high levels of social support reported being never or rarely lonely.

Statistically significant relationships were found between the variables of loneliness and some dimensions of self-reported health suggesting that lonely women tended to report poorer health.

A discussion of the above results will be completed in Chapter IV.
Chapter IV

Discussion

In this chapter, the study results are discussed. The purpose of this investigation was to examine the relationship between the perceived provisions of social support, loneliness, and the perception of health in elderly widows aged 60 years and over. First, the characteristics of the sample are reviewed. Next, the results are discussed in light of existing research and the three main concepts within the conceptual framework: the perceived provisions of social support, the dimensions of health, and loneliness. Finally, the relationships between the perceived provisions of social support and the dimensions of health, the perceived provisions of social support and loneliness, and loneliness and the dimensions of health are discussed. A summary concludes this chapter.

Characteristics of the Sample

The majority of women in this study were older widows with the average age being 71.6 years, and thus fall into the group that is most highly representative of widowhood status in Canada (Statistics Canada, 1996). Close to three-quarters of the widows in this country are over the age of 65. On average, most women become widowed in Canada at age 69 (Martin-Matthews, 1991).
Almost all of the women in this investigation felt it was important to see their family doctor for regular check-ups.

The majority of the women identified themselves as either retired or full-time homemakers. Most of the women were well educated. Lopata’s research with urban widows in the U.S. (1973a, 1979) found that the more education the widow had, the more confidence she demonstrated in her problem solving abilities. This confidence also allowed the widow to trust and accept others more willingly. Thus, all of these factors would contribute to having more personal resources, and a strong foundation from which to deal with conjugal bereavement (Lopata 1973a; 1979).

The range of yearly income for the women in this study varied. Data on average yearly income for older widowed women is not available, however the average income of women 65 years in Canada is $18,139 (Statistics Canada, 1996). Thus, in this investigation, of the women who reported their income, the majority (73%) have annual incomes above the national average. Availability of economic resources has been cited as a primary factor in well-being (Arens, 1982). It has also been cited as important regarding involvement in activities with family, friends, and neighbors after the loss of a spouse (Robinson, 1995; Arling, 1976). Although the relationship between income and the main variables under
study was not examined. Findings of other research has demonstrated that financial security can affect the way an individual evaluates their health and perceives their social support. Higgins (1989) found that older adults with less economic security were more likely to report that they had poorer health.

Financial security is a major concern for many older adults. Limited resources can lead to decreased spending on food, recreation, and transportation. These factors can lead to poorer nutrition, social isolation, and possibly less use of health care resources. The result is an increase in health problems and a poorer self-evaluation of health status (Higgins, 1989). Similarly, (Shank & Lough, 1989) found that perceptions of social support were higher in those older adults who had financial security and reported their health as very good or excellent. Certainly feeling healthy and having the resources to participate in social activities can improve one's opportunities for social interaction and social support. In this study, the women were financially secure, had high perceptions of their social support, and reported their health as very good or excellent.

Most of the women had been married between 40-50 years and widowed between 6-18 months. The relationship between years married and length of time widowed was not correlated with the variables under study. However, there is some evidence in the literature to suggest that it can take at least one year to
accept the loss of a spouse both intellectually and emotionally, and two to three years to develop a new sense of oneself within the world (Jacobson, 1986).

The majority of women in this study had children. There is evidence in the literature to suggest that children can be a strong support for their mothers during bereavement (Silverstein, & Bengtson, 1994; O’Bryant & Morgan, 1990; Antonucci, 1985a).

Study Results in Relation to Existing Literature - The Perceived Provisions of Social Support

The women in this investigation had high scores overall in all of the social provisions with the exception of nurturance (the sense that others rely on one for their well-being), where the mean was low. This would suggest that in this investigation, the widows did not perceive that they felt needed by others. Cutrona and Russell (1987) suggest that for older people facing a role loss such as widows experience, nurturance is an important provision in the maintenance of physical health. In contrast, women in the current study did not perceive that they were needed, and still reported very good physical health. Unlike the findings in other studies regarding the relationship between feeling needed and physical health (Cutrona & Russell, 1987), the women in this study had at some point utilized the support services available to them through the hospices. This may explain why
they reported good health even though they perceived that they were not needed by others. The majority were also financially secure and well educated. Both of these factors may also account for their reports of good health (Higgins, 1989; Lopata, 1973a, 1979).

The highest scores for the social provisions in this investigation were found in the provision of alliance (the assurance that someone can be depended on for tangible support) with a mean of 3.34 (SD=.27). In another study that examined the effects of stress and social support on the health of 50 elderly respondents (24 of whom were not married), the mean score for the provision of alliance was also the highest of all the social provisions in that investigation (Cutrona, Russell, & Rose, 1986). These results demonstrated that the perception of receiving this provision was valuable in reducing stress and promoting the psychological well-being of the elderly respondents. Similarly, the women in this study believed they could call upon a number of individuals in their support system if they needed financial assistance or help with housework, groceries, etc. The perception of the availability of this provision may have increased their confidence and reduced feelings of helplessness, and improved their well-being. Again, the fact that the majority of these women had utilized the support services of the hospices at some point may account for these findings.
On average, the scores on the provision of attachment were also high, and were in fact, the second highest scores for all of the social provisions. It was expected that since these women had all lost their husbands between 6 and 24 months, that they might have had lower scores in this provision. Weiss (1974) suggested that the loss of a major attachment figure (spouse) can cause major distress for the individual causing them to feel insecure, restless, and lonely. It is possible, that these women found that the relationships they had with their friends, support group members, and children substituted for their loss. Thus, in their perception, their needs for closeness and security were being met. This finding contradicts the literature which suggests that losing a partner represents the loss of a major attachment figure, and support from family and friends can not compensate the individual (Stroebe, Stroebe, Abakoumkin, & Schut, 1996; Wilson, Calsyn, & Orlofsky, 1994; Weiss, 1973; Bowlby, 1969). It also contradicts some of the studies that suggest that children are not considered strong supports during conjugal bereavement (Stylianos & Vachon, 1993; Lund, Caserta, Van Pelt, & Gass, 1990). It may also be that the adaptation to the widowed status in this sample had occurred by the time they had participated in this study (Parkes & Weiss, 1983), and therefore most of these women had the time to adjust to their new role, since on average they have been widowed for
about a year. The support provided by the hospices to many of these women may also account for these findings. Finally, it should be noted that the sample in this study was small, white Anglo-Saxon, and not necessarily representative of the general widowed population in Canada.

The Dimensions of Self-Reported Health

The scores for all of the dimensions of health were high, with the exception of vitality and role limitations due to emotional problems. The women in this study believed themselves to be healthy and reported their overall health as "very good". This contradicts some of the literature which suggest that widowhood leads to a perception of poorer health (Poncar, 1989). However, there is some evidence in the literature that suggests that even if a functional limitation exists, as long as there is no severe disability, older individuals will generally evaluate their health as good or excellent (Idler & Kasl, 1991). It may be that functional limitations are accepted by the older adult as part of the normal aging process, and thus do not affect their evaluations of their health.

The highest scores were reported for social functioning. Half of the women reported that they had no limitations or disabilities due to personal or emotional problems, and could perform their social activities without any problems. In the dimension of role-emotional the majority of the women had
high scores and reported that their emotional status did not interfere with work or daily activities. No other studies were found to support the above findings in relation to how emotional status can affect work and daily activities in older widows.

The mental health dimension, also had high scores with half of the women reporting that they felt peaceful, happy, and calm frequently. Thus, as a group these women gave self-reports that they were mentally healthy. Ware et al. (1997) found that mental health scores were higher for the older age groups than for the younger age groups. The majority of women in this study had a high income and were a well educated group of older women. They had family and community supports (hospices) available to them. These factors together may account for the findings regarding mental health in this group of women.

Overall the scores for measures of physical health status (physical functioning, role physical, and bodily pain) were high. In particular, physical functioning scores, which suggested that overall these women reported very few if any limitations in their physical activities due to health. For role-physical, which measures the extent of disability in everyday activities due to physical problems, almost half of the women reported no problems with work or daily activities due to physical health. Bodily pain scores were high as well, with over one quarter of
the women reporting no pain or limitations due to pain.

The average score for the dimension of vitality, which measures energy level and fatigue, was the lowest for all of the subscales of the SF-36. This is similar to other reports where vitality scores for those 65 years and over are the lowest for all age groups (Ware et al., 1997).

In the dimension of general health, the scores were generally high. Over half of the women reported favorable evaluations of their overall general health. This is in keeping with reports from another study that suggests that unless the older individual has a severe disability, the self-report of overall health will be positive (Idler & Kasl, 1991).

On average, for the Reported Health Transition item (2), only a few of the women reported that their health was “much better” compared to one year ago. On average, the women had been widowed for 13.7 months, thus suggesting that it may take at least one year after the death of a spouse for a woman to report that she feels healthier (Parkes & Weiss, 1983).

Over half of the women felt that their health had remained “about the same”. In a study currently underway as part of the Medical Outcome Study, preliminary results show that for more than one third of those people who report that their health remains the same, significant changes actually occurred (Ware et
al., 1997). Again, it may be that unless a severe disability is perceived, the older individual will not report a difference.

Loneliness

The overall scores for loneliness in this investigation were low. Those widowed less than one year reported being rarely lonely, while those widowed between one to two years reported never to rarely being lonely. This was an unexpected finding as it was anticipated that higher scores would have been found in light of the literature which identifies loneliness as a problem for women especially within the first year of bereavement (Anderson & Dimond, 1995; Hegge, 1991; Rokach, 1989). The findings from this investigation may be consistent with the findings of (Ferraro, Mutran, & Barresi, 1984) that suggest that women widowed between one and four years are more likely to increase their involvement with friends. This increased involvement with friends may act to protect individuals from loneliness. It may be, that contrary to some literature which suggests that it can take up to three years to reconstruct one’s world and adapt to the role of widow (Jacobson, 1986), that the women in this study have adapted more quickly, by increasing their involvement with new friendships (widows in support group) and utilizing the resources available to them through the hospices. It may be that agreeing to participate in a study influences the way
in which some women respond to questions. All of these factors may account for the reports of lower loneliness.

**Relationships Between Study Variables: The Perceived Provisions of Social Support and The Dimensions of Self-Reported Health**

Several statistically significant relationships were found between these variables. Guidance correlated positively and strongly with vitality and mental health. Guidance also correlated positively but moderately with physical functioning, role limitations due to physical problems, general health, and social functioning. (Table 4).

The positive, strong relationship between guidance and vitality would suggest that those women who felt that they were receiving guidance (information and advice) from a trustworthy person during the stressful time of bereavement, were also reporting that they felt energized. Similarly, the positive, strong relationship between guidance and mental health would suggest that those who perceived themselves to be receiving information and advice were also more likely to report feeling peaceful, happy, and calm. For many older women, the death of a spouse may mean that they must deal with life’s stressors alone. Some may not feel as though they are adequately prepared to do this. Thus, the availability of advice and information can greatly reduce this stress. The
availability of guidance has been shown to promote psychological well-being in older populations (Cutrona, Russell, & Rose, 1986) and has been cited as important to good mental health after the death of a spouse (Weiss, 1974). For the women in this study, the support provided by the hospices may have also provided them with the guidance they needed.

The positive, moderate relationship between guidance and physical functioning, role limitations due to physical problems, general health, and social functioning in this study, suggest that the availability of advice and information can lead to self-reports of: 1) no activity limitations or problems with work due to physical health; 2) excellent or good health; and 3) continued involvement in normal social activities without interference related to physical or emotional problems. These findings further support those in the literature that the availability of advice and information has a positive effect on health and the way a woman evaluates her health after the loss of a spouse (Cutrona & Russell, 1987; Cutrona, et al., 1986).

The social provision of worth had positive, moderate relationships with physical functioning, role limitations due to physical problems, general health, and vitality (Table 3). Thus, these relationships suggest that those women who felt that others recognized their competence and skills felt valued. Women who
felt valued were also more likely to be able to carry out all kinds of physical activities, including the most vigorous without restriction. They also were more likely not to have any problems with work related to their physical health, and to report feeling more energetic and full of pep. The sense that one has the respect of one's peers can increase self-esteem and have a direct influence on physical health in elderly populations (Cutrona & Russell, 1987; Cutrona et al., 1986).

Social integration correlated positively and strongly with general health and vitality. It also correlated positively but moderately with bodily pain, social functioning, role limitations due to emotional problems and mental health. Once again, those who perceive that they “belong” are more likely to: 1) evaluate their health as good or excellent; 2) feel energized and full of pep; 3) have no complaints of pain or limitation; 4) be able to carry out their social activities 5) have no problems with work or other activities as a result of emotional problems; and 6) report feeling peaceful, happy, and calm more often. Contrary to some literature (Krause, 1986) which suggests that highly socially integrated older individuals can suffer more during bereavement because of the demands placed on them by others, the results from this investigation suggest otherwise. The feeling that one “belongs” to a network of family and friends and has the support of those members can positively affect health (Silverstein & Bengtson, 1994; Dimond et.
Finally, these women were also more likely to report feeling energetic and full of pep, if they felt like they belonged. In this investigation, feeling like one is a part of a group positively affected how one evaluated one’s health status.

Surprisingly, the provision of attachment (emotional closeness giving one a sense of security), yielded only two moderately positive relationships with the dimensions of general health and role-emotional. Women who felt an emotional closeness with another person were more likely to evaluate their health as very good or excellent, and were more likely to report having no problems with work or daily activities as a result of their emotional status. It was particularly surprising that the relationship between attachment and mental health was not statistically significant in this study ($r=.33$, $p=.074$). It could be that the women in this study were able to successfully compensate for the loss of their spouse with the relationships they had with the other widows in their support group (if attended), and their children, and that this compensation was sufficient enough to protect them from poor mental health.

All of the relationships between the provision of nurturance (the sense that one is relied on for their well-being) and the dimensions of health, with the exception of nurturance and social functioning, were inverse negative
relationships and did not approach statistical significance in this investigation (Table 3). This may be due to the low scores for nurturance as reported by the majority of the women.

None of the relationships between alliance (the assurance that someone can be depended on for tangible support) and the dimensions of health approached statistical significance. It may be that in this study, there was not a wide enough range in the scores on these variables for a linear relationship to be detected (Burns & Grove, 1997).

Finally, guidance and worth correlated negatively and strongly with the Reported Health Transition item (2). As discussed earlier, this item asks the individuals about the amount of change in their health in general over a one year period. In this investigation, the majority of the women reported that their health had remained “about the same”. This finding is consistent with preliminary results from another study that is currently underway (Ware et al., 1997). In this report, 57.5% of the older individuals with one or more chronic conditions reported that their health was “about the same” as one year ago. It may be that the availability of advice and information and the respect of one’s peers is not the right type of support to influence the report of general health from “about the same” to “much better”. It may also be that receiving this type of support allowed
them to maintain their health over the year and prevent any deterioration in both physical or mental health.

The Perceived Provisions of Social Support and Loneliness

In this study, all of the relationships between the social provisions and loneliness were inverse weak relationships, with one exception. An inverse and moderate relationship between attachment and loneliness was the only statistically significant relationship detected ($r=-.36$, $p=.048$). The results from this study show that those women who perceived that they had attachment relationships probably felt secure and comfortable and subsequently not lonely. This is in contrast to the findings of other studies (Russell, Cutrona, Rose, & Yurko, 1984; Weiss, 1973), that found that a deficit in the provision of attachment resulted in an “emotional loneliness” for individuals. The findings of Russell et al. (1984), further supported the work of Weiss (1973) which demonstrated that a “social loneliness” exists when the provision of social integration is not met. As mentioned previously, there is a belief that the loss of a spouse can not be replaced by attachment to other members of one’s network (Weiss, 1974; Peplau & Perlman, 1982). It would appear that at least in this study, there is a suggestion that the support of other widows, family, and friends may serve to protect the
widow not only from a "social loneliness" but from an "emotional loneliness" as well.

Loneliness and The Dimensions of Self-Reported Health

The relationship between loneliness and self-reported health yielded several inverse and statistically significant relationships. Loneliness correlated negatively and moderately with vitality, social functioning, and role limitations due to emotional problems. There was a negative and strong relationship between loneliness and mental health. Similarly, Russell (1996), found that loneliness was significantly related to self-ratings of health status in an older population. Thus, the results in this study suggest that a better evaluation of one's health is related to rarely or never feeling lonely. Those women who reported having more energy, being able to carry out social activities, having no emotional problems, and feeling peaceful, happy and calm were less lonely.

Summary

It was originally anticipated, based on the conceptual framework for this study, that as a stressful life event, the loss of a spouse would influence one's perception of support and affect both physical and mental health negatively. There are numerous studies in the literature to support the negative effects that conjugal bereavement can have on health. This was not the case in this
The results from this investigation yielded some surprising results in light of existing research. The characteristics of the sample in this study may account for some of these findings. Education, income, and length of widowhood, are demographic factors that may influence a widow’s ability to deal with the loss of a spouse and adapt to a new role. Specifically, education and financial security can contribute to one’s self confidence (Lopata 1973a, 1979) and well-being (Arens, 1982), thus providing the individual with added resources from which to draw strength as she adapts to widowhood.

These women had overall high scores in the area of the perceived provisions of social support, thus indicating that they believed that they were receiving the six support provisions of Weiss’s model (1973), referred to throughout this chapter. Perception of social support has been identified as an important factor in good physical and mental health (Ploeg & Faux, 1989; Schank & Lough, 1989; Krause, 1987). High social support can reduce the negative impact of stress on mental health.

Overall, the women reported their health as very good. They placed a high value on looking after themselves, so that they could continue to see friends and family and continue with their lives.
Finally, although some of the women reported rarely being lonely, many also reported never being lonely. It could be that the variety of supports that they had in their lives including the support from the hospices and the relationships with other widows, children, and friends, protected them from feeling lonely. It could also be that these women adjusted to widowhood since they have been widowed for about a year. Also, it may be that the stigma attached to admitting that one is lonely is so strong, that it prevents people from expressing their true feelings. Further research is required to clarify the above. The summary, implications, and conclusions of this study are presented in chapter V.
Chapter V

Summary, Implications, and Conclusion

This chapter provides a summary of this investigation. Study limitations, implications for nursing research, theory, and practice, are discussed. Finally, the conclusions of the study are presented.

Summary of the Study

A descriptive correlational study was conducted to examine the relationships between the perceived provisions of social support, loneliness, and the dimensions of self-rated health in elderly widows aged 60 years and over. The relationship between the perceived provisions of social support and the dimensions of self-rated health, the perceived provisions of social support and loneliness, and loneliness and the dimensions of self-rated health were also examined.

A review of the literature pertaining to social support, health, loneliness, and widowhood, assisted in the development of the conceptual framework and research questions. The loss of a spouse has been shown to be a challenging life event (Dimond et al., 1987; Herth, 1990) with those individuals receiving social support more likely to report less loneliness and better health (Russell, 1996). The relationship between perceived social support, self-rated health, and loneliness in
a population of elderly widows had not been previously investigated.

A convenience sample of 30 widows was obtained. The women were recruited from two hospices within a large metropolitan area in Southern Ontario. Network sampling was also used, in order to ensure that a sample of 30 widows was obtained.

Data were collected using: 1) a Demographic Data Sheet (developed by the investigator, 1997) 2) The Social Provisions Scale (Russell & Curtrona, 1987), to measure perceived social support; 3) The Health Status Profile - SF-36 (Medical Outcomes Trust, 1996) to measure self-rated health status; and 4) The University of California (Los Angeles) Loneliness Scale (UCLA) Version 3 (Russell, 1996), to measure loneliness.

The results of the descriptive analyses indicated that overall the women: 1) perceived relatively high levels of social support provisions; 2) reported their physical, mental, and social health as being very good to excellent; and 3) were never or rarely lonely.

Statistically significant, positive relationships were found between several provisions of perceived social support and dimensions of self-reported health. The strongest relationships were found between guidance and vitality, guidance and mental health, social integration and general health; and social
integration and vitality.

A statistically significant inverse but moderate relationship was found between one dimension of social support, the social provision of attachment, and loneliness, suggesting that those women believing that they were receiving this provision were not lonely.

The relationship between loneliness and several dimensions of self-reported health were inverse but moderate: loneliness and vitality; loneliness and social functioning; loneliness and role-emotional; and loneliness and mental health. These results suggest that an evaluation of one's health as good is associated with lower levels of loneliness in one's life.

Study Limitations

One of the limitations of this study was the sample size. A small convenience sample of 30 women was used. Network sampling was also used to ensure that the desired sample size was met. Several biases may have existed within this population because of the sampling methods used. The use of nonprobability sampling increases the chances that the sample will not be representative because not every characteristic of the population under investigation has a chance for being included (Burns & Grove, 1997). In this study, it was not possible to make any generalizations to a larger sample of
widows. This sample was comprised mainly of a well-educated, financially comfortable group of Caucasian women, whose bereavement experience may indeed be very distinct from those widows from a different educational, financial, and cultural background. Some of these women had also utilized services offered through their local hospice.

Second, the Social Provisions Scale, which was used to measure perceived social support, may not have been a reliable instrument in this investigation. Many of the women became annoyed with the “double negatives” used in some of the questions and found them difficult to answer. The women also found some of the negatively worded items in the UCLA Loneliness Scale difficult to answer as well. Russell (1996) cited the difficulty some older individuals have in answering negatively worded items in his own research.

Implications for Research

There are several implications for research based on the results of this study. First, a qualitative study may be able to provide more contextual information especially in the area of loneliness. Some of the women in this study were part of either a formal (through the hospice) or informal (other widows) support group which may have accounted for why the overall scores for loneliness were low. However, a qualitative study might help to further clarify their
experience.

Second, this study needs to be replicated with a larger sample of widows, using a random sampling technique, in order to control for sample bias. This study could also examine widows who seek help during bereavement versus those who choose not to seek help. It would be interesting to ascertain whether or not similar results would be achieved.

Third, more research needs to be conducted in the area of instrument development, particularly those that are being used in gerontological research. Although many instruments, such as the UCLA Loneliness Scale have been reliable and valid when used in younger populations, more research needs to be done using this instrument in older populations.

Fourth, a future study similar to this may consider studying women who have lost their husbands between 6 months to 12 months as opposed to 24 months. It may be that after one year, many women have already begun adapting to their new role, and are indeed coping effectively with loss. In this study, the women had overall high scores for social support, and health and low scores for loneliness.

Finally, the findings of this investigation suggest that bereavement intervention and support may be helpful to older women who have lost their
spouse. A future study comparing widows who receive bereavement support to those who do not would be helpful to add strength to the above findings.

**Implications for Theory**

The results from this investigation have implications for theory. In both attachment theory (Bowlby, 1969; Weiss, 1973), and the relational theory of loneliness (Weiss, 1973), it is believed that the support from close relatives and friends can not compensate for the loss of a major attachment figure (spouse). Thus, because this compensation cannot occur, the result for the individual is the experience of an emotional loneliness, which can only be alleviated by the introduction of another attachment figure. Weiss (1973) goes on to suggest however, that social support can help with a “social loneliness”, which occurs when there is an absence of a social network. In this study, the results suggest that these women have replaced the social support from the attachment figure (deceased spouse), with the social support from their children, and possibly the support they received from the network of friends they enjoyed. Some women were also receiving support at some time from one of the two hospices in their community. The support scores for the provision of attachment were the second highest for all of the social provisions (x=3.23, SD=.314), suggesting that these women felt secure and comfortable. This is hardly what one would expect in light
of their loss and the suggestions within the above theories. Further research is required to examine the processes used by older bereaved women when compensating and replacing lost social support sources.

**Implications for Practice**

The results of this study have implications for nursing practice and the interventions to be used. First, it is important that nurses understand the complex and multidimensional nature of social support, in order to better assess the unique needs of the conjugally bereaved older woman. In addition, understanding the normal aging process and the multiple losses that accompany this process, may be beneficial in understanding the adaptation and coping strategies used by older widows at different stages of bereavement.

Second, it is important to appreciate the influence that one’s perception of their support can have on how they view their health, even when several health limitations exist. This knowledge can guide the nurse when he/she is assisting the widow to evaluate their available resources. All of this information in turn, is important when deciding the amount and type of referral to be made. For those women who have sufficient resources, as in this investigation, focusing on individual strengths and how to utilize them may be productive. Bereavement support groups that focus on guidance, personal growth opportunities, and the
acquisition of new coping skills, versus the disruptive effects of loss, may be more appropriate for the healthy widow who has a strong support system, but still needs some assistance in dealing with her new role as widow.

Finally, being able to ascertain who is at greater risk for being lonely is important. A trusting relationship between a knowledgeable practitioner and client may encourage the client to speak about their loneliness experience without consideration given to social stigma. For those women for whom loneliness does not pose a continuous problem, a preventative approach may be appropriate. Nursing interventions that encourage friendships and alliances with groups that the individual cares about may be beneficial. Encouraging the involvement in activities where the focus of attention is shifted away from oneself (volunteer grandparenting etc.) can also provide fulfillment and possibly decrease loneliness. These involvements and continued contact with people and informal and formal support groups that have meaning for the bereaved older woman, may act to prevent feelings of loneliness, by giving one a sense of connectedness to their world.

Conclusions

The results of this descriptive correlational study, suggest that a high perception of the provisions of social support can lead to a self-report of very
good to excellent physical, mental, and social health, and rare or no loneliness. in older women who have lost their husbands between 6 and 24 months. The findings of this study partially support the literature which shows a strong relationship between perceived social support and better health in older populations. However, the findings do not support the literature on loneliness, where there is strong evidence to support that bereaved and relatively healthy older women are at risk for becoming lonely after the loss of their spouse. Many of the women in this study received a variety of support services from the hospices in their communities. The support received from these organizations may be an important factor in reducing loneliness during conjugal bereavement. Further research on why some older widowed women are more vulnerable than others to loneliness during conjugal bereavement is required.
References


Appendix A
Demographic Data Form

Interview Code Number

A. Age

___(years)

B. Do you see a family doctor for regular examinations?

Yes ___ No ___

C. Employment Status:

1. Employed full time outside the home Yes ___ No ___
2. Employed part time outside the home Yes ___ No ___
3. On a leave of absence Yes ___ No ___
4. Full time homemaker Yes ___ No ___
5. Retired Yes ___ No ___
6. Unemployed Yes ___ No ___

D. Highest Level of Education Completed:

1. Grade School ___
2. High School ___
3. College ___
4. University: Undergraduate degree ___
   Masters degree ___
   Doctorate degree ___
E. Annual Household Income:

1. Less than $10,000
2. 10,000 to $19,000
3. 20,000 to $29,999
4. 30,000 to $39,999
5. 40,000 to $49,999
6. $50,000 or greater

F. Number of Years Married

1. 0-10 years
2. 10-20 years
3. 20-30 years
4. 30-40 years
5. 40-50 years
6. 50 years and over

G. Length of Time Widowed

___ (months)

H. Do you have any children? Yes ___ No ___
Appendix B

Social Provisions Scale

© Daniel W. Russell & Carolyn Cutrona, 1984

Instructions: In answering the following questions, think about your current relationships with friends, family members, co-workers, community members, and so on. Please indicate to what extent each statement describes your current relationships with other people. Use the following scale to indicate your opinion:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

So, for example, if you feel a statement is very true of your current relationships, you would respond with a 4 (strongly agree). If you feel a statement clearly does not describe your relationships, you would respond with a 1 (strongly disagree).

1. There are people I can depend on to help me if I really need it. _____
2. I feel that I do not have close personal relationships with other people. _____
3. There is no one I can turn to for guidance in times of stress. _____
4. There are people who depend on me for help. _____
5. There are people who enjoy the same social activities I do. _____
6. Other people do not view me as competent. _____
7. I feel personally responsible for the well-being of another person. _____
8. I feel part of a group of people who share my attitudes and beliefs. _____
9. I do not think other people respect my skills and abilities.

10. If something went wrong, no one would come to my assistance.

11. I have close relationships that provide me with a sense of emotional security and well-being

12. There is someone I could talk to about important decisions in my life.

13. I have relationships where my competence and skill are recognized.

14. There is no one who shares my interests and concerns.

15. There is no one who really relies on me for their well-being.

16. There is a trustworthy person I could turn to for advice if I were having problems.

17. I feel a strong emotional bond with at least one other person.

18. There is no one I can depend on for aid if I really need it.

19. There is no one I feel comfortable talking about problems with.

20. There are people who admire my talents and abilities.

21. I lack a feeling of intimacy with another person.

22. There is no one who likes to do the things I do.
23. There are people I can count on in an emergency.

24. No one needs me to care for them.

Scoring:

A score for each social provision is derived such that a high score indicates that the individual is receiving that provision. Items that are asterisked should be reversed before scoring (i.e., 4-1, 3-2, 2-3, 1-4).

1. Guidance: 3*, 12, 16, 19*

2. Reassurance of Worth: 6*, 9*, 13, 20

3. Social Integration: 5, 8, 14*, 22*

4. Attachment: 2*, 11, 17, 21*

5. Nurturance: 4, 7, 15*, 24*

6. Reliable Alliance: 1, 10*, 18*, 23
Appendix C

The SF-36 Health Survey

**Instructions:** This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

   Excellent.................................................................1
   Very Good.................................................................2
   Good...........................................................................3
   Fair............................................................................4
   Poor............................................................................5

2. **Compared to one year ago**, how would you rate your health in general now?

   Much better now than one year ago...............................1
   Somewhat better now than one year ago..........................2
   About the same as one year ago.....................................3
   Somewhat worse now than one year ago..........................4
   Much worse now than one year ago...............................5
3. The following are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>Yes, Limited A Lot</th>
<th>Yes, Limited A Little</th>
<th>No, Not Limited At All</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Lifting or carrying groceries.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. Climbing several flights of stairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. Climbing one flight of stairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. Bending, kneeling, or stooping.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. Walking more than a kilometre</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. Walking several blocks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. Walking one block</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

<table>
<thead>
<tr>
<th>j. Bathing or dressing yourself</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cut down on the amount of time you spent on work or other activities.</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>b. Accomplished less than you would like.</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>c. Were limited in the kind of work or other activities.</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>d. Had difficulty performing the work or other activities (for example, it took extra effort).</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
5. During the past 4 weeks, have you had any of the following problems with your or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cut down the amount of time you spent on work or other activities.</td>
<td>1</td>
</tr>
<tr>
<td>b. Accomplished less than you would like.</td>
<td>1</td>
</tr>
<tr>
<td>c. Didn’t do work or other activities as carefully as usual.</td>
<td>1</td>
</tr>
</tbody>
</table>

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

   Not at all .......................................................... 1
   Slightly ............................................................. 2
   Moderately ........................................................ 3
   Quite a bit ......................................................... 4
   Extremely .......................................................... 5

7. How much bodily pain have you had during the past 4 weeks?

   None .............................................................. 1
   Very mild ......................................................... 2
   Mild ............................................................... 3
   Moderate ........................................................ 4
   Severe ............................................................ 5
Very Severe.......................................................................................6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all..........................................................................................1
A little bit.........................................................................................2
Moderately.......................................................................................3
Quite a bit.......................................................................................4
Extremely.......................................................................................5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks

<table>
<thead>
<tr>
<th></th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>A Good Bit of the Time</th>
<th>Some of the Time</th>
<th>A Little of the Time</th>
<th>None of the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Did you feel full of pep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. Have you been a very nervous person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>c. Have you felt so down in the dumps that nothing could cheer you up?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d. Have you felt calm and peaceful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>e. Did you have a lot of energy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Question</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>----------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>f. Have you felt downhearted and blue?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Did you feel worn out?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Have you been a happy person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Did you feel tired?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time......................................................................................................................... 1
- Most of the time......................................................................................................................... 2
- Some of the time.......................................................................................................................... 3
- A little of the time......................................................................................................................... 4
- None of the time........................................................................................................................... 5
11. How true or false is each of the following statements for you?

<table>
<thead>
<tr>
<th></th>
<th>Definitely True</th>
<th>Mostly True</th>
<th>Don’t Know</th>
<th>Mostly False</th>
<th>Definitely False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I seem to get sick a little easier than other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. I am as healthy as anybody I know.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. I expect my health to get worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. My health is excellent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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Appendix D

UCLA Loneliness Scale (Version 3)

Instructions: The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described by writing a number in the space provided. Here is an example:

How often do you feel happy?

If you never felt happy, you would respond “never”; if you always feel happy, you would respond “always”.

<table>
<thead>
<tr>
<th>NEVER</th>
<th>RARELY</th>
<th>SOMETIMES</th>
<th>ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

*1. How often do you feel that you are “in tune” with the people around you?

2. How often do you feel that you lack companionship?

3. How often do you feel that there is no one you can turn to?

4. How often do you feel alone?

*5. How often do you feel part of a group of friends?

*6. How often do you feel that you have a lot in common with the people around you?

7. How often do you feel that you are no longer close to anyone?

8. How often do you feel that your interests and ideas are not shared by those around you?

*9. How often do you feel outgoing and friendly?

*10. How often do you feel close to people?

11. How often do you feel left out?

12. How often do you feel that your relationships with others are not meaningful?
13. How often do you feel that no one really knows you well?

14. How often do you feel isolated from others?

*15. How often do you feel you can find companionship when you want it?

*16. How often do you feel that there are people who really understand you?

17. How often do you feel shy?

18. How often do you feel that people are around you but not with you?

*19. How often do you feel that there are people you can talk to?

*20. How often do you feel that there are people you can turn to?

**Scoring:**

Items that are asterisked should be reversed (i.e., 1=4, 2=3, 3=2, 4=1), and the scores for each item then summed together. Higher scores indicated greater degrees of loneliness.
Appendix E

Explanation of Study from the Executive Director of the Hospice

Letterhead of Participating Site

February 12, 1998

Dear

Linda Scott is a registered nurse, who is currently enrolled in the Masters of Science in Nursing Program at the University of Toronto. She is conducting a study under the supervision of Dr. S. Sidani, at the Faculty of Nursing.

The study will explore how women perceive their relationships and how they are feeling. The information she obtains from this investigation, may be helpful in planning support for other women who have lost a spouse. She would like to have the opportunity to explain her study to you. She will contact you by phone to see if you are interested in learning more about the study. Participation in the study is voluntary. The fact that you agree to allow her to explain her study to you in no way commits you to participating in her study. In addition, your decision regarding participating in this study will, in no way, affect the services you receive from this organization.

Sincerely,

Executive Director

Linda Scott

Msc Candidate
Appendix F

Follow-up Telephone Introduction and Explanation of Study by Investigator

Hello.

My name is Linda Scott. I am a registered nurse and a student in the Master of Science in Nursing Programme at the University of Toronto. As part of the requirements of my programme I am completing a research project under the supervision of Dr. Souraya Sidani, on social support, health, and loneliness in women who have recently lost a spouse.

I understand that the Executive Director from the Hospice sent out a letter briefly explaining my study. I am calling you today to see if you are interested in learning more about the study. Do you have any question(s) regarding the study? Note: If the women express no interest, I will thank them for their time. If they show interest, I will explain the study in the following way: I am interested in the support you feel you have, how healthy you feel you are, and whether or not you feel lonely since the loss of your spouse. I hope that the information I learn from this investigation will assist in the planning of future support for other women who have lost a spouse.

If you agree to voluntarily participate, I will set to meet with you at a time and place that are convenient to you. During the meeting I would ask you questions about: a) the kind and amount of support you think you have; b) how healthy you believe yourself to be; and c) whether or not you feel lonely since the loss of your spouse. The interview should take between 20-30 minutes. Do you have any questions or comments? Are you interested in voluntarily participating in this study?
I agree to participate in a study conducted by Linda Scott who is a registered nurse and graduate student in nursing at the University of Toronto.

I understand that the purpose of this study is to understand the relationship between social support, loneliness, and health in women who have lost a spouse.

I understand that the study will involve one interview in my home. The interview will take 20-30 minutes to complete.

I understand that the interviews involve answering four short questionnaires: one about my personal background such as age and level of education; one about my social support; another about feeling lonely; and another on my health.

The decision to take part in this study is entirely my own. My decision will in no way affect the service and support I currently receive from the Hospice.

I understand that I am free to refuse to answer any specific questions, to stop the interview at any time, and to withdraw from the study at any time.

I understand that some of the questions I will be asked during the interview may trigger an emotional response. I understand that I have the option to terminate or to continue with the interview should this occur.

I understand that I have access to the names of professional services for further counselling should I request this from the investigator.
I understand that I will receive an identification number at the beginning of the study, and that this number will be used to record all answers I share with the investigator.

I understand that at no time will my name be used on any forms or any future published reports.

I understand that although I will not directly benefit from participating in the study, the information I provide may be helpful in planning support for others who have lost a spouse.

I agree to participate in the study.

Dated at ______________ this ___ day of ____________, 1997.

Witness:

____________________________________  _________________________
(Signature of Participant)
October 3, 1995

Linda M. Scott
63 Covent Crescent
Aurora, Ontario
L4G 6R1
CANADA

Dear Ms. Scott:

You have my permission to use the UCLA Loneliness Scale in your research. I have enclosed a paper that describes the newest version of the scale (Version 3) that has recently been accepted for publication. The manuscript, in addition to containing the items from the measure, also presents some psychometric data for this third version of the instrument. I would encourage you to use this new version of the measure in your research, since we have found it works well with elderly samples similar to the one you will be studying. Indeed, the paper also reports some normative data for an elderly sample here in Iowa.

My one request is that you send me a summary of your findings once you have completed your investigation. Good luck with your research.

Sincerely,

Daniel W. Russell, Ph.D.
Professor
Dear Ms. Scott,

The Medical Outcomes Trust is pleased to provide the enclosed information about the SF-36™ Health Survey as specified on your Order Form received October 24, 1997.

We are pleased, by this letter, to grant permission to you to use the SF-36™ Health Survey for non-commercial use. Enclosed are copies of both the more commonly used 4-week recall format and the acute 1-week recall format, either of which you may mechanically reproduce for your use. Also enclosed is a copy of SF-36 Health Survey: Manual and Interpretation Guide as well as reprints of publications that may be of interest to you.

When reproducing the SF-36™ Health Survey please include an identifier as follows:

SF-36™ Health Survey, Copyright © 1992 Medical Outcomes Trust.
All Rights Reserved.
Reproduced with permission of the Medical Outcomes Trust

If you add any questions to it, as users often do, or embed it in a larger questionnaire, please give the larger questionnaire its own name and indicate the following in small type anywhere on the form including at the end: This questionnaire includes the SF-36™ Health Survey, item numbers X to Y in this questionnaire, Reproduced with permission of the Medical Outcomes Trust, Copyright © 1992.

If for any reason you change the wording of any part of the SF-36™ Health Survey, or delete any questions or responses, please do not refer to it as the SF-36™ Health Survey. This is for purposes of standardization of content, scoring, and labeling. We wish to assure users that the designation SF-36™ Health Survey refers to the identical instrument and scoring rules in all cases. This will allow comparison of scores across multiple reports.

The information you have provided on the Project Registration Form will allow the Trust to keep apprised of current projects. If you should later plan to use the SF-36™ Health Survey in additional outcomes measurement activities, we ask that you simply complete a Project Registration Form and forward it to the Trust. I have enclosed a blank Project Registration Form. The Trust in this way can be informed of progress in the field, be alert to the need for new technology and information, promote standardization, and generally serve to advance the field.

We will put you on our mailing list. A brochure describing the Trust's Membership Program has been included for your review. If you have any questions about the materials you received, please contact Daniel W. Krueger, Program Coordinator, at (617) 426-4046.

We wish you the best of good fortune in pursuing your goals in outcomes measurement. Please contact us if we can be of further assistance.

Respectfully,

 Lyn Paget
Lyn Paget, MPH
Vice President

Enclosures

This portion of the letter will also serve as your receipt.
April 6, 1998.

Ms. Susan Pilon  
Office of Research Services  
Room 133S, Simcoe Hall  
27 King’s College Circle  
Toronto, Ontario  
M5S 1A1  

Protocol #3117- Widowhood: The Relationship between Social Support, Health, and Loneliness

Dear Ms. Pilon:

I am writing this letter to inform you of minor changes in the protocol for recruiting subjects for protocol #3117. These changes consist of: 1) having hospice staff inform potential participants of the study; 2) having hospice staff obtain the subjects phone number for the investigator if they are interested in participating in the study; and 3) the recruiting of potential subjects through network sampling.

The first two changes were suggested by hospice staff as an alternative to the investigator attending support groups to introduce the study herself. Hospice staff felt that it was in the best interest of their clients if they both introduced the study, and made a follow up call to obtain permission to pass their phone number to the investigator.

The recruiting of potential subjects through network sampling involves finding a subject who meets the inclusion criteria through a social network. The women who agree to participate in the study are asked for their assistance in getting in touch with others who also meet the criteria for the study. This change is necessary in order to obtain the required sample size.

If you have any questions please contact Dr. Sidani at the Faculty of Nursing, or the investigator.

Sincerely,

[Signature]

Linda Scott  
63 Covent Crescent  
Aurora, Ontario.  
L4G 6R1  
905-727-7550
University of Toronto

OFFICE OF RESEARCH SERVICES

PROTOCOL REFERENCE #3117

April 29, 1998

Dr. S. Sidani
Faculty of Nursing
50 St. George Street
University of Toronto

Dear Dr. Sidani:

Re: Research protocol entitled, “Widowhood: The Relationship between Social Support, Health and Loneliness” Amendment (April 6, 1998) by L. M. Scott, supervisor Dr. Sidani

We are writing to advise you that the Nursing Committee composed of Rev. D. Graydon, Professors G. Donner and A. Moorhouse has granted approval to the amendment to the above-named research study.

During the course of the research, any significant deviations from the approved protocol (that is, any deviation which would lead to an increase in risk or a decrease in benefit to human subjects) and/or any unanticipated developments within the research should be brought to the attention of the Office of Research Services.

Best wishes for the successful completion of your project.

Yours sincerely,

Susan Pilon
Executive Officer
Human Subjects Review Committee

SP/mr
cc: Dean D. Pringle, Ms. L. M. Scott