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CONJUGAL SUPPORT, FAMILY COPING BEHAVIOURS AND WELL-BEING OF THE ELDERLY COUPLE

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ABSTRACT

The purpose of this study was to test the relationship between conjugal support, family coping behaviours and the well-being of the elderly couple. A multistage sample of 135 couples, 65 years and over, was drawn from users of the health and social system, as well as from non-service users, in a large metropolitan area. Data were collected through home visits. A series of questionnaires to measure conjugal support, family coping behaviours, three indicators of well-being (self-assessed health, life satisfaction and marital satisfaction), and selected control variables were presented in interview format separately to each marital partner by two interviewers. Data analysis was performed on individual and couple data. Results revealed significant positive correlations between availability and reciprocity of conjugal support and well-being of both marital partners and a negative association between conflict within the conjugal relationship and well-being of husbands and wives. Only two cognitive family coping strategies, reframing and avoidance of passive appraisal, were positively related to the well-being of both partners. External family coping strategies related to seeking help outside the elderly dyad were not associated with well-being. Paired t-tests revealed that husbands tended to perceive more support from their spouse and to be more satisfied with their marital life than wives. Wives more than husbands perceived the couple to use more external social support and spiritual support. Repeated

measures analysis of variance revealed that congruency of perception between husbands and wives had an effect on the well-being of the wives only. A path model in which conjugal support has direct and indirect effects on well-being through cognitive family coping strategies is proposed

SOMMAIRE

Le but de cette étude était d'investiguer la relation entre le soutien conjugal, les stratégies familiales utilisées afin de composer avec les difficultés de la vie quotidienne et le bien-être des couples âgés habitant à domicile. Un échantillon de 135 couples, âgés de 65 ans et plus et sélectionnés auprès des utilisateurs de services de santé et de services sociaux d'une région métropolitaine de même que par le biais d'une stratégie "boule de neige", furent visités à domicile. Une série de questionnaires visant à mesurer les variables soutien conjugal, stratégies de comportement, trois indicateurs de bien-être (auto-évaluation de la santé, satisfaction de vie, satisfaction maritale) et certaines variables de contrôle furent présentés séparément aux conjoints masculins et féminins sous forme d'entrevue à domicile. Les conjoints et les couples furent alternativement considérés comme unité d'analyse. Les analyses de corrélation démontrèrent une association positive entre la disponibilité et la réciprocité du soutien conjugal et les trois indicateurs de bien-être. Les conflits dans la relation conjugale furent négativement reliés au bien-être des partenaires. Seules les stratégies cognitives utilisées par les couples pour faire face à leurs difficultés, soit l'évaluation dynamique et le recadrage des problèmes, furent reliées à une perception positive de la santé, à la satisfaction de vie et à la satisfaction

maritale des conjoints. Aucune des stratégies de comportement faisant appel à une recherche de soutien social à l'extérieur de la dyade conjugale ne fut associée aux mesures de bien-être. Des résultats similaires furent obtenus des analyses de variance considérant "le couple" comme unité d'analyse. Des tests de mesures appariées révèlèrent une perception plus positive du soutien conjugal et une plus grande satisfaction maritale chez les hommes; les femmes démontrèrent, quant à elles, une perception d'une plus grande utilisation de leur réseau de soutien naturel et de la spiritualité en tant que stratégies familiales pour faire face aux problèmes. La congruence de perception entre les conjoints concernant tant le soutien conjugal que les stratégies familiales utilisées ne fut associée qu'au bien-être des femmes. Un modèle de relation entre les variables étudiées dans lequel le soutien conjugal a un effet direct et indirect sur le bien-être des conjoints âgés par l'intermédiaire des stratégies cognitives de résolution de problème est proposé.

DEDICATION

I dedicate this work to Normand and David,

my very special social supports

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CHAPTER 1

INTRODUCTION AND STATEMENT OF THE PROBLEM

Increased longevity and a drop in birth rate have contributed to the present situation of a growing proportion of people over sixty five years of age (Statistics Canada, 1986). Because of this growth of the elderly population and the increased utilization of health services associated with aging, new responsibilities are now incumbent on society, particularly in the field of health. More specifically, emphasis is put on seeking ways not only of better understanding the situation of elderly people but also of improving the quality of their lives (National Advisory Council on Aging, 1986, 1989).

One of the factors hypothesized to contribute to the quality of life of elderly people is that of their remaining in their primary environment as long as possible (Ducharme, 1984). Recent data from Statistics Canada reveal that the proportion of married elderly couples living in their own home has risen between 1971 and 1986 (Priest, 1988). Research on the preferred living arrangements of elderly people has demonstrated also that the majority of elderly people prefer to live with a spouse independent of their children (Kobrin, 1981; Shanas, 1979). This trend according to Glick (1979) will continue as couples live for a longer

period after their children's departure from home.

Therefore, finding ways of maintaining the elderly in the community has become a main goal of health professionals and has focused attention on yet another area of interest namely the elderly family. In Canada, two strategies recently have been proposed in the Framework for Health Promotion (Epp, 1986) and mental health policy (Health and Welfare Canada, 1988) to promote the well-being of the elderly in their primary environment: reinforcing their natural support systems and assisting them to enhance their capacity to cope with various problems. However, knowledge in the area of social support and coping is not yet sufficiently developed to allow for the designing of an intervention based on support and coping that would lead to a better quality of life (Cohen & Lazarus, 1980; Di Matteo & Hays, 1981).

At present, conjugal support, acknowledged as the most important source of support for the elderly (Brody, 1981; Depner & Ingersoll-Dayton, 1985; Johnson, 1983; Parmelee, 1983; Stoller & Earl, 1983) and coping have been identified as important contributing factors permitting the elderly to remain within the community (Brody, Poulshock & Maschiochi, 1978; Evans et al., 1975; Palmore, 1976; Townsend, 1965; Wan & Weissert, 1981). Studies of conjugal support (Traupman & Hatfield, 1981; Traupman, Hatfield & Sprecher, 1981) and coping (Felton & Revenson, 1984; Kahana, Kahana & Young,

1987) suggest also that each of these factors is associated with the physical and psychological well-being of the elderly. Nevertheless, the qualitative characteristics of conjugal support, positive and negative, and the family coping behaviours of elderly couples related to well-being are largely unknown. The combined effects of conjugal support and family coping strategies to date have not been explored. Furthermore, the way in which support and coping may work to affect well-being is not yet understood.

The purpose therefore of this study was to test the relationship between selected characteristics of conjugal support, family coping behaviours, and the well-being of community-dwelling elderly couples. Since the recognized goal of nursing is health promotion and more specifically to engage families in the process of learning about and acquiring healthier ways of living (Gottlieb & Rowat, 1987), research considering these variables is relevant for nursing.

CHAPTER II

REVIEW OF THE LITERATURE

Research and theories relevant to the major variables examined in the present study, namely support, coping, and well-being are discussed in this chapter. More specifically, the literature was reviewed according to the following themes :

(1) Social Support and Coping as Factors involved in Community Living

(2) Social Support and Well-Being

(3) Coping and Well-being

(4) The Relationship between Support, Coping and Well-Being

(5) Factors affecting Support, Coping and Well-Being

(6) The Conceptual Framework guiding this research

Social Support and Coping: Factors Involved in Community Living

Elderly Canadians prefer to maintain their independence and to remain at home for as long as possible (Schwenger & Gross, 1987). However, the rate of institutionalization of the elderly in Canada is one of the highest among the industrialized countries of the world and is growing (Schwenger & Gross, 1987; Statistics Canada, 1988). According to some critics, there is a tendency to institutionalize too early and many people in institutions do to not require this level

of care (Schreiber & Hughes, 1982; Sicotte, 1982; Tilquin et al. 1980).

While it is true that physical and mental disability are important factors in placement (Gutman, 1980; York & Calsyn, 1977; Zimmer, 1975), these factors are not the main reasons for admission to long-term care. Lack of support from relatives and friends was found to be an important factor (Branch & Jette, 1982; Brock, 1985; Brody, Poulshock & Maschioci, 1978; Greeberg & Ginn, 1979; Kraus et al. 1976; McAuley & Prohaska, 1982; Palmore, 1976; Smyer, 1980; Townsend, 1965; Wan & Weissert, 1981). In one study, old age and lack of a support network better predicted institutionalization than health and other social variables (Brock, 1985). Kraus et al. (1976) demonstrated that excessive burden of care placed on family members was the first reason given by patients and families for admission to institutions while physicians, on the other hand, gave physical deterioration and old age as the predominant reasons for admission.

Indeed, researchers agree that networks of informal support help keep people out of institutions. The availability of social support lessens the deleterious effects of impaired physical and mental functioning of the elderly (Mor, Wachtel & Kidder, 1985; Weissert & Scanton, 1985). More specifically, family support is acknowledged as being one of the most important factors for continuing life in the community (Bergman, Foster, Justice & Mattews, 1978).

The coping strategies used by the elderly to master the problems of everyday living is another important factor involved in whether or not the elderly remain at home. Evans and colleagues (1975), in a Canadian study, compared a pre-institutional group composed of aged persons who had applied to nursing homes but who had not yet been admitted, and a community group of elderly Canadians who had not applied for institutionalization. The authors found a tendency in the community sample to regard their health as good and stable, regardless of their limitations in daily activities. The community group was also more aware of where to obtain health resources than the pre-institutional group.

Even though social support and coping strategies are key factors in community living, their relationships with well-being have not been fully described. The following sections are an overview of the existing literature on social support, coping and well-being.

Social Support and Well-Being

Theoretical Approaches

Research on social support and well-being has conceptualized well-being in various ways. Physical and psychological health and life satisfaction have been the criteria most often used to define well-being (Larson, 1978).

The positive relationship between social support and physical and mental health has been investigated in a wide

array of studies as evidenced in the number of review papers on this subject (Cassel, 1976; Cobb, 1976; Cohen, 1988; Cohen & Wills, 1985; Dean & Lin, 1977; Kaplan, Cassel & Gore, 1977). The literature highlights two models for describing the relationship between social support and health. Much of the interest is directed to the stress-buffering hypothesis in which social support is posited to provide a buffer against the effects of stress. In this model, it is the interaction between stressors and social support that is important for health (Brow, Bhrolchain & Harris, 1975; Cobb, 1976; Dean & Lin, 1977; Nuckolls, Cassel & Kaplan, 1972). The main-effect model in which social support is presumed to have a direct beneficial effect on health regardless of whether persons are under stress is the alternate model. In this model, social support is considered as an important variable in its own right (Andrews, Tennant, Hewson & Vaillant, 1978; Schaefer, Coyne & Lazarus, 1981; Turner, 1981; Williams, Ward & Donald, 1981).

Cohen and Wills (1985) reviewed social support studies to compare these models. They concluded that there was evidence consistent with both models but that the models are not mutually exclusive. How social support is conceptualized and measured affects the evidence for both hypotheses.

Social Support and Well-being in the Elderly

In the gerontological literature, one of the continuing concerns has been the nature of the elderly's social support and its association with the health of older persons (Kohen, 1983). Despite the accumulated evidence of a positive relationship between social support and health of the elderly, the association remains, as for other age groups, modest and the precise nature of the relationship is not well understood (Black, 1985; House, Robbins & Metzner, 1982; Kasl & Berkman 1981).

Few researchers have examined the direct relationship between social support and physical and psychological well-being in the elderly living in the community (main-effect model). Blazer (1982) found that social support had a high predictive value for mortality in persons 65 years of age and over. Turner, Frankel and Levin (1983) reported a modest association between social support and psychological well-being in a study of 989 physically disabled, community residents. People having social support were less anxious and less depressed. Laschinger (1984), however, failed to find a relationship between social support and functional health and psychological well-being in the elderly. These conflicting findings might be explained by conceptual and methodological issues related to the study of social support.

Conceptual and methodological issues. Most instruments used to measure social support focus either on the more objective or structural dimension of social support, such as the number of people in an individual's environment and the frequency of contact with them, or on the more subjective appraisal of the adequacy or satisfaction with different dimensions of support (Donald & Ware, 1984). The relationship between the quantity of social support and physical status has been studied extensively in recent years (Broadhead et al., 1983) with many of the early studies employing only objective measures to indicate level of support (Bruhn & Philips, 1984; Rock, Green, Wise & Rock, 1984; Tardy, 1985). This approach assumes that the benefits of social support are related to the size and range of an individual's social network and that having a relationship is equivalent to receiving support from that relationship.

Although the importance of the family to the well-being of the elderly has been stressed in the literature (Spark & Brody, 1970; Troll, 1971), structural indicators of family interaction have been shown to exhibit little relationship to morale, life satisfaction or other indices of subjective well-being in the elderly (Blau, 1981; Cohler & Lieberman, 1980; Harel & Deimling, 1984; Lee, 1985; Liang, Dvorkin, Kahana & Mazian, 1980; Mancini, Quinn, Gavigan & Franklin, 1980; Ward, LaGory & Sherman, 1982). Stoller(1984), using

a probability sample of 753 non-institutionalized older persons, found that the quantity or the amount of informal support may have a negative impact on self-assessments of health by the elderly. People with more social support assessed their health lower than those with less social support. The exchange perspective which postulates that high levels of assistance create a power imbalance and place the person in the role of dependent recipient was used to interpret Stoller's (1984) findings.

The foregoing results, however, must be interpreted in light of the particular conceptualization and operationalization of social support utilized in these studies. Social support, according to Thoits (1982), represents more than simple quantity of social ties; rather support resides in the actual fulfillment of needs. As pointed out by Bruhn and Philips (1984), the concept of social support probably continues to be ambiguous because the phenomenon has been quantified before it has been defined satisfactorily.

Some authors have attempted to address these weaknesses. It has been suggested that support is probably most effective when the provision is viewed by the recipient as appropriate or adequate (Antonucci, 1985; Cohen & McKay, 1984). Investigating the relationship between quality versus quantity of social support and well-being, Duff and Hong (1982) found that the quality (satisfaction with social support) rather than the quantity of social support (fre-

quency of contacts) among the elderly was the more critical variable for their life satisfaction. Similarly, Ward, Sherman, and LaGory (1984) demonstrated that subjective network assessment (perceived sufficiency of involvement and satisfaction) had a stronger association with morale of the elderly than objective assessment (number, frequency and proximity of social ties). Strain and Chappell (1982), in a Canadian study using a stratified random sample of 400 persons aged 65 and over, found that a confidant relationship implying intimacy and reciprocity was more important to the quality of life (satisfaction and happiness) than the number of interactions with family or friends.

Recent research also provides evidence that the perception of reciprocity, defined as the mutual giving as well as receiving of support (Mitchell, 1969), is an important element in the effect of social support on well-being of the elderly (Antonucci, 1985; Ingersoll & Antonucci 1983; Wentkowski, 1981). Ingersoll and Antonucci (1983) examined reciprocity within the elderly's relationship with spouse, child, and friend. Reciprocity with spouse was positively associated with levels of happiness. Similarly, Wentowski (1981), in an anthropological study on dimensions of network building, revealed the significance of reciprocity for preserving the self-esteem of older people.

Within the last decade, literature has reflected an alternate perspective on social interactions, one that

considers interactions as neither free nor always benevolent. According to those holding to this position, social interactions may involve implicit expectations, costs and conflict as well as support (House, 1981; Wellman, 1981). Fisher (1982) suggested that one reason for the modest association found in many studies between social support and well-being is that psychological costs of personal relationships subtract from their many benefits. Consequently, studies incorporating the notion that support may be upsetting for the elderly, that is taking into account "the darker side of social support" (Tilden & Galyen, 1987) have been forthcoming in recent years.

Fiore, Becker and Coppel (1983), investigated the relationship between perceived network "upset" and "helpfulness", and depression among 44 caregivers of a spouse with a diagnosis of Alzheimer's disease. The correlations between perceived network upset and depression were highly significant while in no case did perceived helpfulness relate to depression. Similarly, Robinson (1989) found that network upset (defined as "when wished support was not provided") predicted depression better than network helpfulness.

Rook (1984) measured the effect of problematic versus positive social ties on psychological well-being of the elderly. She conducted structured interviews with 120 elderly subjects. Subsets of questions led to the clustering

of data into supportive social ties, problematic social ties (persons who invaded privacy, broke promises, took advantage, or caused feelings of anger and conflict) and combined supportive and problematic social ties. Using multiple regression analyses, the problematic social ties showed more potent effects on well-being than supportive social interactions. Rook (1984) compared these findings to those of Mueller, Edwards and Yarves (1977) and Sarason, Johnson and Siegel (1978) who found that negative events demonstrated a more stronger influence on the psychological status of an individual than positive events.

Social exchange theory has long emphasized that social interaction entails both rewards and costs. Studies based on equity theory have indicated that the greater the perceived inequity, the greater the distress (Fisher, Nadler & Alagna, 1982; Leventhal, Allen & Kemelgor, 1969; Walster, Berscheid & Walster, 1973). Exchange theory also posits that reliance on informal helpers for assistance with tasks of daily living might lead to an unbalanced exchange relationship, which in turn can have a negative effect on subjective morale (Dowd, 1975). Help provided by others may inadvertently reinforce sick role behavior or dependence (DiMatteo & Hays, 1981).

Evidence related to the developmental course of close relationships suggests that the balance of positive to negative exchanges shifts over time, such that negative

exchanges become increasingly common (Rands & Levinger, 1979). Increasing changes and asymmetry in interaction characterize social relationships of older persons (Depner & Ingersoll-Dayton, 1985; Kahn, 1979; Rands & Levinger, 1979). With increasing age, maintaining a balanced exchange relationship becomes increasingly difficult as the need for help expands and the cost of providing support increases. Researchers who fail to assess the negative dimensions of social support may overlook a particularly important source of explanation in well-being.

In summary, a potential paradox seems to exist in relation to social support and well-being of the elderly. On the one hand, considerable research exists which supports the conclusion that social support is essential for the well-being of the older individual. On the other hand, a separate body of evidence points to the opposite conclusion which is that social support may detract from the well-being of the elderly. The contribution of both the positive and negative dimensions of support to the well-being of the elderly largely has been ignored in research (Powers, 1988). Studies incorporating both dimensions would further our understanding of the link between support and well-being. No study has yet considered simultaneously the positive dimensions of support, i.e. perceived availability and reciprocity, and the negative side, i.e. conflict, as predictors of well-being of the elderly.

Conjugal Support and Well-Being in the Elderly

Recent studies on family and health have identified marital status and conjugal support as being the most potent family factors affecting overall mortality and morbidity in the general population (Campbell, 1986). Some studies have suggested that it is the quality of the marriage that plays an important role in health (Goves, Huges & Style, 1983; Verbrugge, 1979). Research on middle-aged populations has shown that conjugal support, in particular, is a significant positive factor influencing the quality of physical and emotional well-being of the individual as well as life and marital satisfaction (Burke & Weir, 1977; Pratt, 1972). More specifically, the perceived exchange of various instrumental and emotional elements between partners such as love, information, money, goods and services, was found to be positively associated with marital satisfaction (Rettig & Bubolz, 1983). On the other hand, lack of reciprocity with a spouse has been found to be a significant source of psychological distress (Hatfield, Utne & Traupmann, 1979; Ilfeld, 1982).

Although the presence of a spouse was found to be a major factor in preventing institutionalization of the elderly (Brody, Poulshock & Maschiochi, 1978; Palmore, 1976; Townsend, 1965), the relationship of conjugal support with the well-being of the elderly has received little attention to date (Sussman & Steinmetz, 1987). Two studies however

which represent efforts in this area were those of Traupman and Hatfield (1981) and Traupman, Hatfield, and Sprecher (1981) who found a positive effect of love on mental and physical health of the elderly and demonstrated that "fairness" was important in the marital satisfaction of older women. Ward (1985) pointed out, however, that it is too often assumed with the elderly that relations with a spouse necessarily involve positive support in the form of affection and assistance. The reciprocal nature and the conflict involved in support may influence its potential beneficial impact (Unger & Powell, 1980). The perceived positive and negative aspects of conjugal support have never been simultaneously explored in relation to the well-being of the elderly dyad.

Coping and Well-Being

Theoretical Approaches

Various conceptualizations of coping have been proposed within recent years and the role of coping in relation to well-being has received increasing attention. The majority of the studies on coping have focused on coping resources. Coping resources refer to personal attitudes, beliefs and skills that are available to people to deal with stress or changes that occur in their lives (Kobasa, Maddi & Courington, 1981; Kobasa, Maddi & Khan, 1982; Wheaton, 1983). This coping perspective does not refer to what people do in a

problematic situation but rather to what is available to them in developing their coping repertoire.

Other recent approaches have broadened the conceptualization of coping to include cognitive and behavioral responses or efforts made to master, tolerate or reduce demands that tax or exceed a person's resources, i.e coping strategies (Lazarus, 1981; Moos, 1977; Pearlin & Schooler, 1978). Diverse conceptualizations about salient dimensions of coping strategies have been put forth based on studies of adult populations. Billings and Moos (1981) distinguished among active behavioral, active cognitive, and avoidance-oriented strategies as the critical components of coping while Pearlin et al. (1978) differentiated coping strategies that change the situation, change the meaning of the situation, or control the stress of the situation. Folkman and Lazarus (1980) proposed a bidimensional formulation of coping based on problem versus emotion-focused dimensions.

There is mounting evidence that how people cope with stress may be more important to overall morale, social functioning and somatic health than the frequency and severity of the stress episodes themselves (Benner, Roskies & Lazarus, 1980; Billings & Moos, 1981, 1984). Nevertheless, the majority of the coping literature deals with the coping behaviours people use in handling specific stressful life events such as illness, death in the family, loss of job and so forth (Ben-Sira, 1983, 1984; Billings et al., 1981; Cohen

& Lazarus, 1980; Felton, Revenson & Hinrichsen, 1984; Folkman et al., 1980). In fact, most research on coping focused on coping with major "life events" and used the stress-buffering model of coping, neglecting its main effect or its possible effect on existential or daily stress (Lazarus & DeLongis, 1983; Noh & Turner, 1987; Pearlin et al., 1978).

A major conceptual problem still existing in much of the research on coping relates to the lack of a clear distinction between coping strategies and the outcomes of coping. A number of investigators have argued that it is important to separate the coping strategies that are used to deal with a stressful situation from the outcomes or the effectiveness of these strategies (Horowitz, 1979; Kahana et al., 1987; Kessler, Price & Wortman, 1985). At present, however, there are little data that relate coping behaviours to outcomes. In the few studies in which coping is differentiated from its outcomes, coping outcomes have generally been assessed in terms of psychological distress reactions, such as depression and anxiety (Menaghan, 1983b; Pearlin et al., 1978; Pearlin et al., 1981) rather than psychological well-being.

Coping and Well-Being among Middle-Aged and Older Adults

Some coping strategies have been found to reduce the distress associated with many life experiences in middle-aged and older adults. Pearlin et al. (1978) undertook an

extensive study in which they interviewed a sample of 2500 people, aged 18 to 65 to determine the kinds of coping strategies they used to deal with daily problems and how efficacious these were in reducing emotional stress. Results showed that the individual's coping interventions were most effective when dealing with problems within the close interpersonal areas of marriage, that these problems were best handled by coping mechanisms in which the individual remained committed to and engaged with the relevant others, and that a greater repertoire of coping was more protective than a limited one. This study is noteworthy because it is one of the few to describe the everyday coping experiences of people as opposed to coping with specific stressors. In another study, the use of active and problem-focused coping responses was found to be related to lower levels of depression whereas the use of responses that served to avoid actively confronting a problem were related to more depression (Billings et al., 1981).

Very few studies have considered the relationship between different coping strategies and positive outcomes such as adjustment or well-being (Felton & Revenson, 1984; Felton, Revenson & Hinrichsen, 1984; McCrae & Costa, 1986; Kahana et al., 1987). Felton and Revenson (1984) in a study on the stress of illness considered adjustment as the outcome of coping and found that a problem-focused coping strategy, namely "information seeking", had a salubrious

effect on adjustment while an emotional strategy "wish-fulfilling fantasy", had deleterious consequences. In general, research in this field has demontrated that cognitive and problem solving strategies, such as information seeking and rational action, are related to life satisfaction and positive affect while emotional strategies, particularly those involving avoidance, blame and emotional ventilation, are related to negative affect, lowered self-esteem and poorer adjustment (Felton, Revenson & Hinrichsen, 1984; Mc Crae & Costa, 1986).

Until the 1980s, research on coping typically excluded those 65 years and older. The work which has been carried out since then with older populations has looked primarily at relationship between personality characteristics, as coping resources, and distress reactions (Krause, 1986; Simons & West, 1985; West & Simons, 1983). Few investigators have sought to identify specific effective coping behaviours among the elderly. Kahana, Kahana, and Young (1987) studied the coping strategies of an elderly population facing institutionalization. In a longitudinal study they examined the relationship between diverse self-reported coping strategies and well-being among 253 older adults entering 14 long-term care facilities. Instrumental coping strategies were related significantly to high morale and good mental functioning. Affective coping had a significant relationship to low morale, poor self-esteem, and poor mental function-

ing. In spite of their changed living situation, that is in an institution, elderly respondents tended to maintain their characteristic coping styles, thus providing evidence for a traitlike quality of coping or stability in coping (Felton et al., 1984; McCrae, 1982).

This study, (Kahana et al., 1987), is one of the only studies found which considered the coping strategies of the elderly as related to their well-being. Coping was assessed, as in the majority of studies, in the face of a particular stressful event, namely institutionalization. The coping behaviours of the elderly in the face of ordinary problems or circumstances are still unknown.

In summary, there has been a dearth of research addressing the effectiveness of diverse coping strategies among older persons. Moreover, no research has addressed the effectiveness of diverse coping strategies used by the elderly in the face of daily stressful situations. The research literature in social gerontology is replete with studies of life satisfaction or other measures of subjective well-being (for review see Larson, 1978) but few of these studies have incorporated the construct of coping in their theoretical models.

Family Coping and the Family Paradigm

Very little attention has been directed toward understanding how families develop effective ways of responding to life circumstances (McCubbin et al., 1980) or which

family coping patterns work or fail in different kinds of families (Berardo, 1980; McCubbin et al., 1980; Turk, 1979). Shifting from the individual level to a family level of coping becomes complex (Olson & McCubbin, 1983).

One premise states that within relationships, overtime individuals will develop and maintain a shared perspective of the world (Berger & Luckman, 1966). Reiss (1981) expanded this argument in stating that families over time develop a "paradigm" or shared world view. Therefore, family-level coping necessarily involves exchange of perspectives and efforts at coordination of decisions and actions, an interpersonal activity (Menaghan, 1983a).

Despite the complexity, inroads into family coping have been made. Hill's (1949) ABCX family crisis framework and its expanded version, the Double ABCX model of adjustment and adaptation (McCubbin & Patterson, 1983) have served as the foundation for most research on family stress. Such research has focused on crisis events or on the family coping with negative events such as separation (Lavee, McCubbin & Patterson, 1985; McCubbin, Dahl & Hunter, 1976) or children's chronic illness (Hymovich & Dillon Baker, 1985; McCubbin et al., 1982). A major criticism of these studies is that they do not describe how families cope but rather how individual family members cope.

In one cross-sectional study with intact families across the life cycle, Olson and McCubbin (1983) inves-

tigated family coping with everyday problems and produced a picture of family coping behaviours. Family coping strategies were conceptualized as a set of interactions within the family (internal family coping strategies) and transactions between the family and the community (external family coping strategies) wherein family resources, perceptions and behavioral responses identified in family stress theory (Hill, 1949; McCubbin et al., 1983) were integrated. Results of this study revealed that seeking spiritual support, an external family coping strategy, was the strategy reported most often b elderly marital partners as their "family coping behaviour" in the face of everyday problems. The second strategy most often reported as helpful by this population was an internal family coping strategy namely "reframing" or the ability to define the stressor as a challenge that can be overcome. The use of informal social support from friends, extended family, and neighbors (external family coping strategy) was placed third in terms of its use by elderly families. Lastly, elderly partners reported that "passive appraisal" or the ability of the family to define the stressor as something that will take care of itself over time (an internal family coping strategy) was not a family strategy they used often.

The foregoing study (Olson et al., 1983), is particularly noteworthy in that it is one of the only published studies to date which has focused on "non-pathological"

healthy families. While it made a major contribution to the field of family research, the relationship between the coping behaviours of elderly couples and their well-being was not addressed.

A major conceptual problem in most family studies is that coping often is equated with adaptational success. Menaghan (1983b) reviewed the few existing criteria for assessing coping effectiveness in individual and family research. The three most common indicators of effective coping in the studies reviewed were: (1) perceived helpfulness (Berman & Turk, 1981; McCrae et al., 1986; Mc Cubbin et al., 1976), (2) reduction in emotional distress (Pearlin et al., 1978; Pearlin et al. 1981) and , (3) reduction in problem (Menaghan, 1982, 1983a). Based on this review, Menaghan (1983b) proposed alternative criteria such as health and well-being for assessing coping effectiveness. The McGill Model of Nursing (Gottlieb & Rowat, 1987) also delineates well-being and quality of life as possible outcomes that follow from coping. However, little research has been done on the relationship between these outcomes and family coping behaviours.

Family Coping and the Well-Being of the Elderly

The current goal of maintaining older people in the community has generated a new interest among health professionals in the family. However, most of this interest has focused on those families in which there has been an ill

elderly member. Considerable research therefore on the stress and burden of family caregivers has appeared in the literature in the past decade (Barer & Johnson, 1990). The most recent trend in gerontological research is to describe the coping behaviours of caregivers and to relate these to the caregiver's sense of burden (Pratt, Schmall, Wright & Cleland 1985) or well-being (Barusch, 1988; Quayhagen & Quayhagen, 1988).

However, this body of literature has considered the perception of only one family member to assess family coping, namely the caregiver, and has concentrated in the main on the coping of families in the face of degenerative conditions such as Alzheimer's disease. Pratt et al. (1985) for example found that two internal family coping strategies (confidence in problem-solving and reframing the problem) and two external family coping strategies (use of spiritual support and extended family) were negatively related to caregiver burden scores. Similarly, Barusch (1988) found that the diversity of problems encountered by the elderly spouse caregivers required a varied repertoire of coping techniques. Help-seeking with care management and health related problems were particularly helpful for the caregivers. The family coping behaviours of "healthy" elderly couples in the face of everyday problems has yet to be explored for their possible relationship with couples' well-being.

Social Support, Coping Behaviours and Well-being

Although a number of studies document the importance of social support and coping behaviours for well-being, few studies focus specifically on the inter-relationship among these variables (Billings et al., 1981, 1984; Mc Nett, 1987; Pearlin et al. 1981). Indeed, most research on social support has progressed independently from research on coping (Gore, 1985). When social support and coping have been considered simultaneously, they have been conceptualized as intervening processes mediating the effect of life events (stress-buffering effect) on health, the latter of which generally has been conceptualized as the absence of distress.

Pearlin and colleagues (1981), in their classic study on the stress process among 1106 adults between the ages of 18 and 65, looked at the amalgam of multiple life problems that may result in depression and physical disorders. They found that both social support and coping were mediators in the stress-distress process. Similarly, Billings et al., (1981) explored the nature of individual coping responses and social resources in attenuating the stress of life events in a representative adult community sample of 194 families. Coping (active-cognitive and active-behavioral coping responses) and social support (quantitative and qualitative indicators) attenuated the relationship between undesirable life events and personal functioning, measured

by mood and physical symptoms. The severity of the event and the coping measures were not related. In a more recent study, the role of stress, social resources and coping among 424 men and women entering treatment for depression was explored (Billings et al., 1984). Stressors, social resources, and coping, additively, were found also to be predictive of patient's functioning.

In the foregoing studies, coping and social support were considered for their stress-buffering effects. The mechanism through which social support and coping might work to improve well-being in ordinary circumstances is still unknown. Social support has been suggested as having an indirect effect on well-being through enhancing effective coping (Cobb, 1976; Cohen & McKay, 1984; Lazarus & Folkman, 1984). McNett (1987), in one of the only studies which considered how social support and coping are related, used a path analysis to test the theoretical relationships among social support, coping, and well-being proposed by Lazarus and Folkman (1984). Perceived availability of social support, but not the use of social support, was significantly and positively related to well-being and functioning through the mediating variable of coping.

In conclusion, the literature has highlighted the importance of considering the inter-relationships between social support, coping, and well-being outcomes. In the main, these relationships were tested in the face of

stressful events using the stress-buffering model. Social support and coping, in combination, were predictive of health. In one study (McNett, 1987), social support was found to be directly and indirectly related to well-being through coping.

No research was identified that has systematically considered the nature of support (positive and negative dimensions) and coping behaviours in the context of the family. More precisely, conjugal support and family coping behaviours in relation to everyday problems have never been studied in terms of their relationship to the well-being of the elderly.

Factors Affecting Social Support, Coping and Well-Being

Variables such as functional ability, socio-economic status, level of stress, years married, social network size and gender all have been found to influence either the well-being of the elderly, social support, or coping.

Functional Ability

Antonucci (1985a) found evidence that frailty is an important factor affecting supportive interchange. The needs of the frail elderly pose a special demand on the support network, especially on the spouse (Cantor, 1980). Need for functional care also tends to predict non-reciprocity (Antonucci, 1985). In addition, functional limitations have been shown to be negatively related to well-being (Clark &

Anderson, 1967).

Socio-Economic Status

Socioeconomic factors have been related consistently to well-being of the elderly. In Larson's (1978) review of the literature on well-being, socioeconomic factors followed health as the most important predictor of subjective well-being. Socioeconomic status has also been related to social support and coping (Antonucci, 1985). People from a higher socioeconomic status generally report greater community involvement (Spakes, 1979). Lower class couples report more distress and a more difficult adjustment to retirement than those from middle and upper classes (Dressler, 1973).

Level of Stress

A large body of research has examined the stress and changes precipitated by life events associated with aging and the effects of these changes on the well-being of the elderly (Amster & Krauss, 1974; Atchley, 1982; George, 1980; Lowenthal, Thurnher & Chiriboga, 1975). More specifically, aging is linked to changes in role obligations, financial circumstances and health status (Lazarus & DeLongis, 1983; Stokes & Gordon, 1988). There is empirical evidence that the stress generated by these changes and situations may have a negative influence on the subjective well-being of the elderly (Amster & Kraus, 1974; Elwell & Maltbie-Crannell, 1981). Furthermore, it was found that such stress may change the dynamics of the marital relationship, specifically

increasing requirements for conjugal support (Depner & Ingersoll-Dayton, 1985).

Social Network Size

Although weak, some evidence does exist to support the hypothesis that the size of an individual's social network (the number of known relatives, friends and neighbors) may be related to a certain extent to support and well-being of that individual (Harel et al., 1984; Liang et al., 1980).

Years Married

A large body of research has explored the changes in marital satisfaction over time. Researchers generally have found a U-shaped pattern, with marital satisfaction high among those recently married, somewhat lower among those in the childrearing period and higher again in the later stages of the family life cycle (Burr, 1970; Rollins & Cannon, 1974; Spanier, Lewis & Cole, 1975). Somewhat contrary findings were reported by Burke and Weir (1982) who found that couples married longer showed a diminished level of helping activities between them, a decrease in communication, and a greater "criticalness" of each other's functioning as a helper. Years married seems more important than age per se for well-being. No relationship has been found between age and well-being (Larson, 1978; Palmore & Luikart, 1972).

Gender

The literature suggests that women overall report providing more support than men (Corin, 1982; Kahn & Antonucci, 1984). Consequently, husbands seem to receive more support (Stinnet et al., 1970), and wives are less likely than husbands to report receiving support from their partners (Depner & Ingersoll, 1985). Men are more likely than women to rely exclusively on the spouse as the sole source of health care and consultation (Depner & Verbrugge, 1980). Men also report higher levels of marital satisfaction than women (Antonucci & Depner, 1982; Campbell, Converse & Rogers, 1976). Social support and coping taken together were found to account for more of the variance in functioning among women than among men (Billings et al., 1981).

Conceptual Framework

The conceptual framework guiding this study, namely the McGill Model of Nursing, emphasizes family, coping, and well-being (Gottlieb & Rowat, 1987). Within this framework, the more specific concepts of conjugal support, family coping behaviours, and well-being were chosen for study. Conceptualizations of these variables judged to be compatible with the model were utilized. Conjugal support and family coping behaviours were considered as two distinct but interrelated phenomena that may explain a significant proportion of the variance in subjective well-being of

elderly marital partners living at home.

Conjugal Support

The conceptualization of conjugal support used in this study was based on social exchange (Blau, 1964; Homans, 1974) and equity theory (Burgess & Huston, 1979; Foa, 1971; Messick & Cook, 1983) which hold that human relationships involve exchange of valued commodities, the pursuit of which produces rewards and costs. Exchange theories have shown that conflict arises when one partner in a relationship is dissatisfied with the exchange achieved (Scanzoni, 1979).

Social exchange and equity theories suggest that the positive aspects of support are not the only important dimensions of the concept. Conflict, as a negative side of support, should also be considered.

Therefore, conjugal support was defined, in the present study, as the perceived interpersonal relationship between marital partners comprising both positive and negative aspects. Two positive dimensions were considered: (1) Availability or Enactment of helping behaviours related to love, status, information, goods and services (Foa, 1971) and, (2) Reciprocity or exchange of helping behaviours between the marital partners. As a negative side of conjugal support, Conflict was defined as the perceived discord in the conjugal relationship caused either by behaviours enacted by the spouse or by the withholding of supportive behaviours from the spouse.

Family Coping Behaviours

The conceptualization of family coping used in this study was based upon McCubbin et al.'s (1983) framework in which family coping behaviours are considered an integral part of a family's total repertoire of adaptive behaviours. Family coping is viewed as a set of interactions within the family (internal family coping) and transactions between the family and the community (external family coping) as a response to demands imposed by everyday situations or problems. Coping is considered as a concept which has intrafamily cognitive processes (ability to redefine the stressful situation into manageable components) and active and passive behavioural responses designed to maintain the integrity of the family and the integrity of its members (McCubbin & Thompson, 1987). This conceptualization is congruent with the one used in the McGill Model of Nursing (Gottlieb & Rowat, 1987) in which coping is defined as the efforts to deal with everyday situations and in which an enhanced quality of life is the ultimate outcome.

Well-Being

The conceptualization of well-being used in this study drew upon a quality of life framework. More specifically, well-being was conceptualized as part of the general concept of quality of life and as a multidimensional subjective phenomenon.

The science of quality of life currently being developed (Andrews & Withey, 1976; Campbell, Converse & Rodgers, 1976; Flanagan, 1982; George et al., 1980; Holmes, 1989; Katz, 1987; McCullough, 1984; Spitzer, 1987; Warner & Williams, 1987) refers in part to the way in which individuals perceive and evaluate their own life experience. As pointed out by McCullough (1984), the concept of quality of life is individually structured and therefore is a subjective phenomenon.

Physical health is a part of the foundation upon which subjective dimensions of quality of life rest. It is probably more important for older persons because it is much more likely to be problematic (George & Bearon, 1980). Perceived health has been shown to be a significant predictor of mortality in the elderly (Mossey & Shapiro, 1987), a significant predictor of physiologic health (Kaplan, 1987), and the factor most strongly related to reported well-being among the elderly (Larson, 1978).

There also is substantial evidence that life satisfaction is related to well-being (Andrews et al., 1976; Bradburn, 1969). In the gerontological field, well-being frequently has been conceptualized as synonymous with life satisfaction (Neugarten, Havighurst & Tobin, 1961). The demonstrated relative stability of life satisfaction (Andrews et al., 1976), as well as its link to the achievement of serious and desired goals probably makes it a more

attractive measure of subjective well-being than the more emotional and transitory reports of morale or happiness (George & Bearon, 1980). Campbell et al. (1976) reported from a nationwide study that individuals responded in terms of life satisfaction when asked specifically about their quality of life. Thus, there is a growing consensus that life satisfaction is the most important dimension to include in any quality of life measure (Ferrans & Powers, 1985).

Finally, a common feature of quality of life studies is the measurement of satisfaction with a specific facet of the life experience, such as marital satisfaction (Andrews et al., 1976; Campbell et al. 1976; Olson et al., 1983). Therefore, well-being was conceptualized in the present study as encompassing three related subjective dimensions namely: (1) Self-Assessed Health, (2) Life Satisfaction and (3) Marital Satisfaction.

Summary of the Literature Review and Research Questions

In summary, the review of the literature has demonstrated that while social support, coping, and well-being have been theoretically and empirically linked, no attempt has been made to systematically explore the relationship among the positive and negative dimensions of conjugal support, family coping behaviours, and well-being of the elderly couple in the face of problems of everyday living. Most research on the elderly has considered their total social

network and has examined how individuals cope, without considering interactive properties of support and shared ways of managing difficulties or family coping. Moreover, the outcome measure used in the majority of studies has been an illness/distress reaction. A better understanding of the link between family support, family coping, and family well-being seems a prerequisite to the elaboration of any nursing intervention that might improve the quality of life of the elderly family, namely the elderly couple in the community. Therefore, this study addressed the following research questions:

(1) What is the relationship between the positive and negative aspects of conjugal support and the well-being of elderly marital partners?

(2) What family coping behaviours are related to the well-being of elderly marital partners?

(3) To what extent is well-being of elderly marital partners associated with the characteristics of conjugal support (positive and negative) and family coping behaviours?

CHAPTER III

METHOD

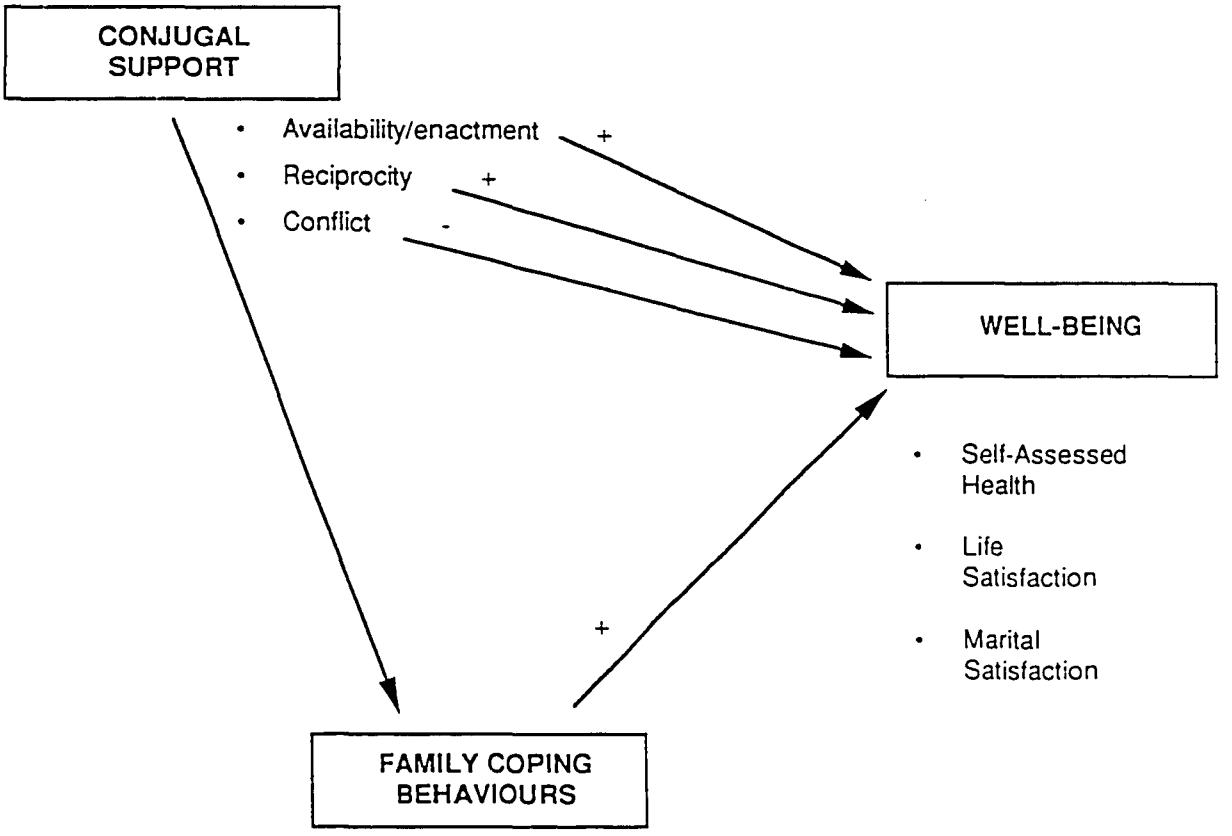
The purpose of this study was to test the relationship between conjugal support, family coping behaviours, and well-being of elderly marital partners living in the community. More specifically, the aim of this study was to find those dimensions of conjugal support and family coping that may account for the variation in the well-being of elderly marital partners living in the community.

Design

A cross-sectional correlational design was used to answer the research questions. This type of observational or nonexperimental research design is used when inferences about relations among variables are made without direct intervention, from concomitant variation of independent and dependent variables (Kerlinger, 1986).

Research Hypotheses

Based on the present state of knowledge concerning the relationship between conjugal support, family coping behaviours and well-being, and the conceptual framework of the study, an hypothesized model of the relationship between the variables was developed (see Figure 1). More specifically, it was hypothesized that:



Internal Family Coping

- Reframing
- Avoiding Passive Appraisal

External Family Coping

- Seeking Spiritual Support
- Mobilizing the Family to Acquire and Accept Help
- Acquiring Social Support

<u>Control Variables:</u> Functional Ability, Socioeconomic Status, Level of Stress, Social Network Size, Years Married, Gender

<u>Figure 1</u>. Diagram of the Proposed Model

(1) There is a positive relationship between the well-being of elderly marital partners and the positive aspects of conjugal support (i.e. perceived availability/enactment and reciprocity of conjugal support).

(2) There is a negative relationship between the well-being of elderly marital partners and the negative side of conjugal support (i.e. conflict in the conjugal relationship).

(3) Conjugal support along with family coping behaviours account for a significant part of the variance in the well-being of elderly marital partners.

(4) Conjugal support has a direct effect on the well-being of elderly marital partners as well as an indirect effect through family coping behaviours.

Setting and Sampling Strategy

The study was carried out in a large metropolitan area. Community-dwelling elderly couples were chosen according to the following criteria:

1. The husband and wife were sixty-five years of age or older.

2. They were living together alone at home (house, apartment or housing unit for the elderly). This criterion was set because the presence of another person might have affected the perception of conjugal support, family coping behaviours, and the well-being of the couples.

3. Both partners had the physical and mental capacities to be interviewed.

4. Both partners spoke and understood English or French.

The sample size was based on statistical power analysis (Cohen, 1977). Thirteen variables were identified to be included in planned regression models for the scores of husbands and wives separately. A sample size of 133 couples was required to detect a moderate effect size (R^2=.13) with an alpha of .05 and a power of .80.

A multistage sample was drawn from users of health and social services as well as from non-service users (Kelsey, Thompson & Evans, 1986). A random sample of ten agencies delivering services to the elderly in the Montreal region was obtained from the 1988 Directory of Community Services of Greater Montreal-Welfare, Health and Recreation (Information and Referral Centre of Greater Montreal Foundation, 1988). The final cluster included: three seniors' community

centers, one day center, three associations and three centres locaux de services communautaires (CLSC's). These services were located in various neighborhoods in the Metropolitan area.

Each of the ten services was contacted in order to explain the goals of the study and to solicit their assistance in selecting subjects. The ten services agreed to participate in the study and lists of couples meeting the study criteria were requested from these selected agencies.

The plan for contacting the couples called for an initial contact by either the nurse (in the case of CLSC's and day centers) or the director (in the case of senior citizen centers or associations). The nurse or the director was asked to explain to the potential subjects, through a phone call as well as by letter, that a nurse was interested in studying how couples 65 years and over manage at home and to request permission to have their names and phone numbers released (Appendix A). The three associations provided a list sufficiently extensive to permit the selection of a simple random sample of couples. Following this step, the researcher telephoned one member of the selected elderly dyad to again explain the purpose of the study and to solicit the participation of both marital partners for individual interviews.

As no sampling frame for couples in the community exists, an additional strategy, namely a snowball strategy,

was used to avoid selection of service-users only. At the end of each home visit, interviewed couples were asked if they would communicate with other couples, friends and acquaintances, who neither received services nor participated in an association, for their permission to be contacted by the investigator. The use of several sources for sample selection increased the variability as well as the representativeness of the sample of the total population of community-based elderly.

Instruments

A summary of the instruments used to measure the study variables with their estimated internal consistency reliabilities is presented in Table 1. Because the interview format has been shown to have particular advantages when used with an elderly population (Kelsey et al., 1986), the measures were administered in face-to-face interviews with each spouse separately. The interview format secures a high response rate, permits interactions and disclosure of feelings and overcomes the sensory problems associated with aging (Kelsey et al., 1986).

A French version of each instrument was developed for the present study through the use of the "double-translation" technique. More specifically, each instrument was translated into French by an independent translator and then translated back to English by two other translators.

Table 1

Measures and Internal Consistency Reliabilities

Measure	Item #	Alpha* Husbands	Alpha Wives
Modified Interpersonal Relationship Inventory(IPRI)	**39**	**.71**	**.71**
1) Availability/ Enactment of Conjugal Support	13	.79	.80
2) Reciprocity	13	.70	.72
3) Conflict	13	.68	.70
Family Crisis Oriented Personal Evaluation Scales (F-Copes)	**30**	**.75**	**.69**
1) Internal Strategies Reframing	8	.74	.70
Passive Appraisal	4	.74	.70
2) External Strategies Acquiring Social Support	9	.64	.62
Seeking Spiritual Support	4	.66	.62
Mobilizing the Family to Acquire and Accept Help	4	.65	.66
Life Satisfaction Index(LSI-Z)	**13**	**.79**	**.79**
Self-Assessed Health (Cantril Ladder)	**1**	**--**	**--**
Marital Satisfaction (Visual Analogue)	**1**	**--**	**--**

* Cronbach's Alpha

Problematic statements were refined by a panel of two bilingual graduate nursing students. The French version was then pilot tested with five French couples and three bilingual couples who were asked to report on the comparability of the English and the French versions of the instrument. In the following section, each of the research instruments is described.

Conjugal Support: The Interpersonal Relationship Inventory (IPRI, Tilden, 1987)

Few investigators have integrated the negative aspects of social support in their measuring tools (McFarlane, Neale, Norman, Roy & Streiner, 1981; Procidano & Heller, 1983). To assess the negative as well as the positive dimensions of social support, Tilden (1987) developed the Interpersonal Relationship Inventory (IPRI).

Based on social exchange (Blau, 1964; Homans, 1974) and equity theories (Burgess et al., 1979; Foa, 1971; Messick et al., 1983), the IPR Inventory is an interval measure that consists of 39, 5-point likert scale items. For the first 22 items, a 5-point strongly disagree-strongly agree anchor is used and for items 23 through 39 a 5-point never-often anchor is used. According to Tilden (1987), the use of two anchor styles is desirable as it reduces method error that may occur when a scale is too uniform.

The inventory contains three subscales consisting of 13 items each: (1) Perceived Availability or Enactment of

helping behaviours: e.g., "I can turn to my spouse for helpful advice about a problem" (perceived availability) and " My spouse shares similar views with me" (enactment), (2) Reciprocity: e.g., " In my relationship with my spouse, I get just as much as I give" and (3) Conflict: e.g., "My spouse invades my privacy". For each subscale, the theoretical range is 13 to 65, 65 indicating high availability, reciprocity or conflict within the relationship. Factor analysis has shown that Perceived Availability/Enactment and Reciprocity can be added in order to derive a single score for Positive Social Support. The Conflict score stands alone as an index of interpersonal stresses. Items from the three subscales are mixed to avoid response sets. This instrument requires 10 to 15 minutes for the general population to complete and slightly longer for elderly persons (Tilden & Galyen, 1987).

Items were derived initially from qualitative interview data from 44 respondents and were written to be congruent conceptually with the multidimensions of interpersonal relationships within support networks. The last testing demonstrated that the instrument has sound psychometric properties (Tilden, 1987). Each item was examined for its distribution, factor-loading, item-to-total correlation, test-retest correlation, missing data or other indices of wording problems, and conceptual strength relative to the original qualitative data from which it was derived.

Cronbach's alpha for the total scale (n=97) was .76 and ranged from .78 (Reciprocity) to .89 (Perceived Availability/Enactment). Test-retest reliability for each subscale (2 week interval) ranged from .81 (Conflict) to .91 (Perceived Availability/Enactment).

The IPRI was designed to assess interpersonal relationships within the social network of people. Therefore, permission was granted from the author to use a modified version of the instrument in which the word "spouse" replaced the words "people", "someone", "friends", "person", "others", "neighbors" in order to assess only the conjugal relationship (Appendix B). Pilot testing of the French version led to the rewording of seven items in order to increase the clarity of the questions (Appendix B). Cronbach's alpha coefficients for the total scale and the subscales appear in Table 1. Cronbach's alpha was .81 for husbands and .80 for wives when Perceived Availability/Enactment and Reciprocity were combined.

Family Coping Behaviours: Family Crisis Oriented Personal Evaluation Scales (F-Copes, McCubbin, Olson & Larsen, 1987)

Family coping behaviours were measured by the Family Crisis Oriented Personal Evaluation Scales (F-Copes, McCubbin, Olson & Larsen, 1987) which were created to identify pattern of strategies utilized by families facing daily problems or difficulties. F-Copes is a questionnaire which draws upon the coping dimensions of the Double ABCX

Model (McCubbin et al., 1983). The instrument contains 30 items that describe family coping strategies and which focus on two levels of interaction: (1) the ways a family internally handles difficulties and problems between its members and (2) the ways in which the family externally handles problems or demands.

The instrument consists of five subscales. Three subscales contain items assessing how families externally handle problems by using active behaviours to acquire resources outside the family system, namely: (1) Acquiring Social Support (9 items), a measure of the family's ability to actively engage in acquiring support from relatives, friends, neighbors and extended family: e.g., " When we face problems or difficulties in our family, we respond by seeking encouragement and support from friends", (2) Seeking Spiritual Support (4 items): e.g., " When we face problems or difficulties in our family, we respond by attending church services", and (3) Mobilizing the Family to Acquire and Accept Help (4 items) which assesses the family's ability to seek out community resources and accept help from others: e.g., "When we face problems or difficulties in our family, we respond by seeking assistance from community agencies and programs designed to help families in our situation".

Two subscales contain items assessing how families internally handle problems by using resources residing

within the system namely : (1) Reframing (8 items) which assesses the family's capability to redefine stressful situations in order to make them more manageable: e.g., "When we face problems or difficulties in our family, we respond by knowing that we have the strength within our own family to solve our problems", and (2) Passive Appraisal (4 items) which evaluates the "inactive" or passive behaviours a family might employ: e.g., "When we face problems or difficulties in our family, we respond by believing that if we wait long enough, the problem will go away". One item stands alone: e.g., " When we face problems or difficulties in our family, we respond by exercising with friends to stay fit and reduce tension" (Appendix C).

Each family member is asked to respond to the 30 items on a five point likert scale ranging from strongly disagree (1) to strongly agree (5). A sum score for each family member can be obtained for each sub-scale and for the total scale by summing the respondent's score for each of the items. To ensure that all items are weighted in the same positive direction, scores for the items included in the Passive Appraisal subscale are reversed. The testing time is approximately 15 minutes.

Repeated validity and reliability checks have been performed with different samples of healthy families at different stages of the life cycle, including retirement families. Content validity of the F-Copes was established

by identifying the coping strategies from the family coping literature and from a pilot instrument consisting of 49 strategies. Factor analysis reduced the number of items to 30. The last testing (McCubbin et al., 1987) was performed on a large sample (n= 2740) of husbands, wives and adolescents. Five factors emerged from the reliability testing. The five factors' alpha reliabilities ranged from .63 (Passive Appraisal) to .83 (Acquiring Social Support). The total sample was split randomly into two and Cronbach's alpha was computed on the scores of each sample. Cronbach's alpha for the first sample was .86 and for the second sample .87. Test-retest reliability (four-week interval) was .81 for the total scale and ranged from .61 (Reframing) to .95 (Seeking Spiritual Support) for the subscales.

Pilot testing of the French version of the instrument led to the rewording of four items (Appendix C). Cronbach's alpha coefficients for the total scale and for each subscale appear in Table 1.

Well-Being: A Multidimensional Assessment

Well-being consisted of three dimensions namely Self-Assessed Health, Life Satisfaction and Marital Satisfaction. These dimensions were measured using the following three instruments.

Self-Assessed Health: The Cantril Ladder (Cantril, 1965). To measure self-assessed health, Cantril's self anchoring ladder was used (Cantril, 1965). The concept of self-anchoring is derived from transactional theory of human behavior. Central to the theory is that the "reality world" of each of us is always to some degree unique and perceptions are valid indicators of reality (Denzin, 1982).

The self-anchoring scale is one in which the respondent is asked to describe what would be for him/her the very best health status. Following this judgment, the respondent is asked to describe what he/she perceives as the very worst health status for him/herself. Then, the respondent is handed a pictorial ten-point ladder scale and is told that the best and worst health status are the end points of the scale. The interviewer then asks where on the ladder the person would say he/she is now, in terms of health status. Scale-position responses are treated as interval scale data (Kilpatrick & Cantril, 1960). The Cantril ladder takes on the average five minutes to complete (Appendix D).

The Cantril ladder has been administered to adults of all ages (Campbell et al., 1976). This measurement technique has one distinct advantage in that it permits individuals to describe and evaluate their health in terms of their own values.

In a study on life satisfaction, Cantril (1965) recorded verbatim respondents' descriptions of the best and worst futures and categorized these responses. This qualitative approach has been incorporated into the present study in order to determine common themes related to indicators of health status among elderly marital partners.

Life Satisfaction: Life Satisfaction Index-Z (LSI-Z, Wood, Wylie & Schaefer, 1969). The Life Satisfaction Index-Z (LSI-Z) is a modification of the Life Satisfaction Index-A (Neugarten et al., 1961). The original instrument (LSI-A) was designed for a study of psychological and social factors involved in aging and was developed to measure the individual's own evaluations, as a point of reference.

In order to establish the content validity of their measure, Neugarten and colleagues (1961) examined the measures of adjustment and morale that had been used in previous studies and defined distinguishable components. Five dimensions were obtained: Zest, Resolution and Fortitude, Congruence between Desired and Achieved goals, Positive Self-Concept and Mood Tone. In brief, an individual was regarded as being at the positive end of the continuum of life satisfaction or psychological well-being to the extent that he: (1) takes pleasure from the round of activities that constitutes his everyday life (zest) (2) regards his life as meaningful and accepts resolutely that

which life has been (resolution and fortitude), (3) feels he has succeeded in achieving his major goals (congruence between desired and achieved goals), (4) holds a positive image of self (positive self-concept), and (5) maintains happy and optimistic attitudes and mood (mood tone). Adams (1969) and Bigot (1974) subsequently used factor analysis to confirm four clearly discernable factors in the LSI-A: Mood Tone, Zest for Life, Congruence between Achieved and Desired Goals, and a fourth, unnamed dimension.

The LSI-Z used in the present study is the end product of refinement procedures of the LSI-A. It consists of 13 items drawn from the LSI-A. It encompasses the same dimensions as the LSI-A but, as an index of life satisfaction, merely gives a total score. The LSI-Z requires of the respondent to agree or disagree with 13 statements (e.g., "As I grow older, things seem better than I thought they would be", "When I think back over my life, I didn't get most of the important things I wanted"). An answer reflecting a positive orientation of the person towards life, which may be either an "agree" or "disagree", depending upon the particular question, is scored "2". An answer reflecting a negative orientation or an undecided answer is scored "1". Thus, the theoretical range of the instrument is 13 (low satisfaction) to 26 (denoting high satisfaction) (Appendix E).

The appropriateness of the LSI-Z for older samples has been demonstrated. This instrument is short and takes 5 to 10 minutes to administer (George & Bearon, 1980).

In terms of construct validity, Lohmann (1977), in a study of 259 older people found a correlation of .79 between the LSI-Z and the Philadelphia Geriatric Morale scale (Lawton, 1972) and a correlation of .94 between the LSI-A and its offspring the LSI-Z. The LSI-Z was standardized on 100 older persons from Kansas. Internal consistency estimates based on split-half reliability coefficient was .79 (Wood, Wylie & Sheafer, 1969). Cronbach's alpha for the present study appears in Table 1.

Satisfaction with Conjugal Life: Visual Analogue and Open-ended Question. Two instruments, a visual analogue and an open-ended question, were used in the present study to assess the dimension of satisfaction with conjugal life (as part of the overall quality of life). The visual analogue rating scale was used to provide a quantitative measure of satisfaction with conjugal life. Each individual was asked to rate his/her current satisfaction with conjugal life by slashing on a 100 mm visual analogue scale between the extremes labelled very dissatisfied and very satisfied (Appendix F). The score was determined by measuring the distance in millimeters from the zero-valued end of the line to the subject's mark.

The linear analogue scale is easy to use and easy to grasp for subjects (Bond & Lader, 1974). It is convenient and takes only seconds to obtain a score (Aitken, 1969). The results reported by Kaplan and Ernst (1983) and Sutherland, Dunn and Boyd (1983) suggest that visual analogue scales can give reliable and valid results if the response continuum is made clear to subjects. This method has been used to rate subjective feelings (Bond et al., 1974; Zeally & Aitken, 1969) and quality of life (Priestman & Baum, 1976).

Because the visual analogue is a single-item instrument and because the rating of very dissatisfied and very satisfied may mean different things to different people (Campbell, 1976), each spouse was asked to explain his/her rating and their answers were tape recorded.

Measurement of the Extraneous Variables

In order to avoid spurious associations, controlling for the variables found in earlier investigations to be associated with the study variables was important. Consequently, extraneous variables such as functional ability, socioeconomic status, level of stress, social network size, years married and gender were measured in the present study.

Functional Ability: Functional Ability Measure

(Chappell & Strain, 1985)

The Functional Ability Measure is a 12-item instrument in which the subject's capacity to perform (without help) activities of daily living is assessed. Using the telephone, shopping, handling money and dressing are some examples of the activities (e.g. "Are you able to shop for groceries?"). The score on each item ranges from Perform the activity without help (1) to Cannot perform the activity (5). The theoretical range on the index is 12, meaning independence, to 48 meaning complete dependence (Appendix G). The Functional Ability Measure was chosen for its brevity (5 minutes to complete) and its easy applicability to the elderly living in the community (Chappel & Strain, 1985).

This instrument has been used in an extensive study on decision-making among the elderly and the use of health and social services in Manitoba (Chappell & Strain, 1985). It has been found to have strong content and construct validity. Scores on this measure and time spent in the hospital during the past year, time spent ill at home during the past year, need for medical attention at home, and age were found to be highly correlated. Internal consistency in the Manitoba study was .89. In the present study Cronbach's alpha was .89 and .90 for husbands and wives respectively.

Socio-Economic Status, Social Network Size and Number of Years Married

Socio-demographic data were gathered from each marital partner as part of the interview schedule (Appendix H). Questions on the most important occupation prior to retirement, number of years married and the social network were asked. The social network variable was assessed by questions tapping the structural aspect of the network (e.g., "How many of your close relatives do you see or contact regularly?").

Socioeconomic status was determined by the 1981 Socioeconomic Index for occupations in Canada (Blishen, Carroll & Moore, 1987) based upon education and income. The Blishen index is a unidimensional, contextual indicator which locates individuals in the Canadian hierarchy. It assigns precise numerical values to positions in the occupational structure.

To establish the status score for an individual, it is necessary to determine the occupation or, for the retired person, his/her occupation in the past. A score is then assigned to the occupation using the scoring sheet established for 514 census occupations in Canada. Scores range from 4.23 to 101.74; the higher the score, the higher the status. In the present study, the estimated social position of the couple was assumed to be based upon the husband's occupation.

Level of Stress: The Geriatric Social Readjustment Rating Scale (GSRRS, Amster & Krauss, 1974)

The level of stress experienced by the elderly marital partners was measured with the Geriatric Social Readjustment Rating scale (GSRRS). The scale is based on the assumption that change per se is stressful regardless of its desirability and that the impact of such events is additive.

The GSRRS is a checklist of 35 items. The subject is asked if he has experienced any of the events or situations in the last six months. Examples of events or situations are "change in sexual behavior", "eyesight failing", and "losing driver's license". The theoretical total life stress score ranges from 0 (absence of stress) to 1599 (maximum stress). A weight is associated with each event. A score can be obtained by adding the weights associated with each event or situation checked by the subjects (Appendix I). This instrument is rapid to administer.

The GSRRS was developed in the following manner. First, a panel of experts in geriatric medicine modified Holmes and Masuda's (1974) items to make them more applicable to a geriatric population. The resulting 35 items were then reviewed by 30 experts in gerontology. Each of the 35 items was assigned a weight, proportional to the importance attributed to its occurrence by a group of professionals familiar with the geriatric population. To determine the extent to which the judges agreed in their ratings (inter-

rater reliability), Kendall's coefficient of concordance (W) was calculated. The resultant coefficient of .54 ($p < .001$) indicated reasonable inter-observer agreement. Amster et al. (1974) found a significant relationship between the number of crisis events, as well as the magnitude of the events experienced in the preceeding five years, and mental deterioration in old age using the GSRRS.

Data Collection Procedure

The data were collected in the homes of the couples between January 1989 and August 1989. A total of 135 couples were visited.

At the time of the home visit, a further explanation of the project was provided and written consent emphasizing voluntary participation was obtained from each marital partner (Appendix J). Couples were assured that anonymity and confidentiality would be respected and that the data would be treated as aggregate data. To enhance validity and reliability, permission was requested from both partners to tape-record the qualitative data.

To avoid disclosure and consequently social desirability (Dillman, 1983), husbands and wives were interviewed separately in different rooms by the researcher and one trained interviewer (bilingual nurse with a baccalaureate degree). To reduce the possibility of response effects (Bradburn, 1983), the investigator and the interviewer were

randomly assigned a priori to husbands or wives. Settings that afforded the maximum of privacy and comfort were selected for the interview.

In order to reduce the fatigue of the elderly subjects, all the written questionnaires were presented in interview format. Large printed plasticized 5" X 8" cards were given to the subjects to hold and refer to when answering questions involving Likert-type scales. If particular health needs of the couple were identified, these were discussed at the end of the testing period and the subjects' permission for referral, if necessary, was sought. Couples were not asked until the end of the interview about other possible acquaintances who might agree to participate in the study i.e. snowball strategy.

Socio-demographic data as well as data on self-assessed health were gathered first. These data were relatively easy to gather, did not involve much introspection and helped to gain the trust and to establish a relationship with the marital partners. Three questionnaires were then administered in the following order for all subjects: Family Coping (F-Copes), Life Satisfaction Index (LSI-Z), and the Geriatric Social Readjustment Rating Scale (GSRRS). To reduce the fatigue effect, the visual analogue scale and the open-ended question dealing with marital satisfaction followed. Finally, assessments of the level of functional ability and the level of perceived conjugal

support (IPRI) were obtained at the end of the interview. It was judged that the IPRI dealt with the most sensitive issues. Therefore it was administered at the end of the interview schedule.

Pilot testing of the procedure to be followed took place one month prior to the commencement of the study (N= 8 couples). No alterations were judged necessary on the procedure and the order of administration of the instruments. Interviews ranged in length from 45 minutes to 2 hours with an average length of 1-1/2 hours.

Data Analysis Procedures

Quantitative Analysis

Quantitative data analysis was performed on a IBM microcomputer using the 6.03 version of SAS software system for data analysis (SAS Institute Inc., 1987). Initially each variable was subjected to descriptive statistics. To examine "within couple" data, intraclass coefficients of correlation and paired t-tests were calculated.

To explore the relationship between the study variables, individual and couple data analyses were performed. Individual data were analyzed using zero-order correlation coefficients and hierarchical multiple regression analyses. Couple data were analyzed using a mixed design analysis of variance with husband/wife as a repeated measure. The level of significance for all tests was set at $p<.05$.

Qualitative Analysis

Qualitative data concerning subjects' perception of health and marital satisfaction were taped on microcassette recorders. Recordings were transcribed in full into typewritten form using version 5.0 of Word Perfect (Word Perfect Corporation, 1988). Responses in the first thirty interviews were reviewed and categories were generated from the data. The data from the total sample (N=270 interviews) were then independently coded into categories by the researcher and a research assistant. Overlap of categories accounted for all the discrepancies between the raters. Because redundancy was apparent, certain categories were combined.

CHAPTER 4

FINDINGS

This chapter is divided into three major sections. First, the final sample of elderly couples will be described. The relationship between husband-wife data for each study variable will then be presented, followed by answers to the three research questions using individual and couple data.

The Sample

Selection Process

A total of 167 telephone calls to prospective couples were made. Six couples did not meet the study criteria: two individuals were too young and in four couples one spouse was either hospitalized or had recently died.

Only 26 couples refused the home visit resulting in a participation rate of 84.6%. The major reasons for refusal are presented in Table 2. The final sample consisted of 135 elderly couples, 97 of whom were obtained from lists provided by ten randomly selected services and 38 who were referred through the snowball sampling strategy. Figure 2 illustrates the final distribution of the sample.

Table 2

Reasons for Refusing to Participate in the Study

Reasons	n (Couples)	%
Too busy, too many activities (Summer period)	6	23.07
No immediate benefit	4	15.30
Refusal of one partner (Lack of interest)	4	15.30
Pain or illness	3	11.53
Husband at work all day and too tired to participate	2	7.69
Partners did not want to be interviewed separately	2	7.69
Did not like to have strangers in their home	2	7.69
Did not want to give a reason	2	7.69
Had been recently interviewed for another purpose	1	3.84
Total	**26**	**100.00**

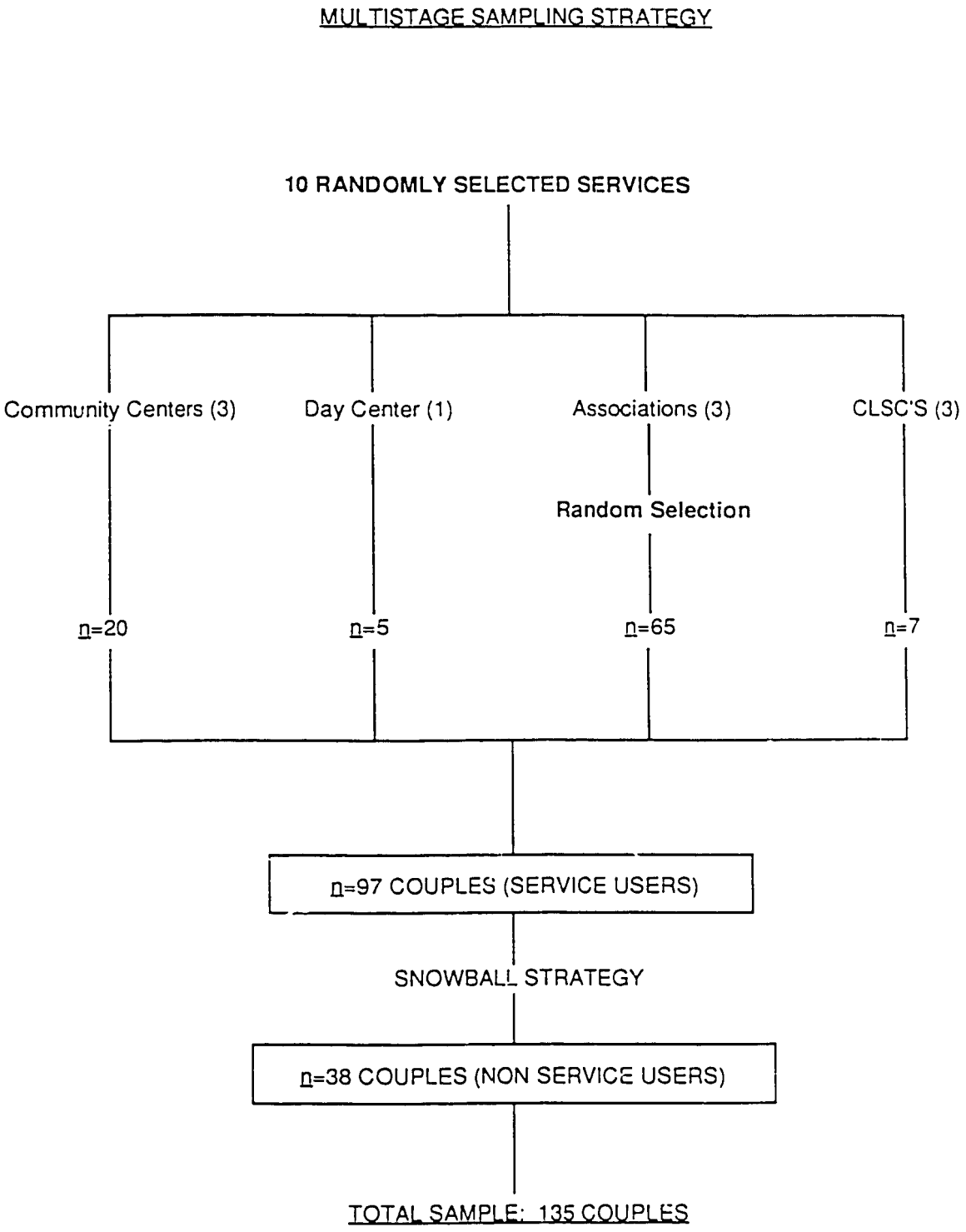


Figure 2. Multistage Sampling Strategy: Final Distribution of the Sample.

Sample Characteristics

Table 3 summarizes the major background characteristics of the final sample of 135 couples. Of particular interest, husbands were slighty older than wives and all men, except two, were retired at the time of the study (See Appendix K for age distribution). All individuals had lived in Canada for more than 30 years. The average duration of the marriages was 42 years. One couple was newly wed while the oldest couple was married for 70 years. The educational level of women was slightly lower than that of men.

To determine if the background characteristics of the samples drawn from the service agencies and the snowball strategy were similar, *t*-tests were performed. The only differences found between the two samples were that the partners selected from the service agencies were significantly ($p<.05$) younger than those selected from the snowball strategy (*M*: 71.1 and 73.2) and were married for a fewer number of years (*M*: 40.7 and 46.5).

Functional ability, size of the social network and level of stress thought possibly to be related to the major variables of conjugal support, coping, and well-being, were measured in the present study. Descriptive statistics performed on these extraneous variables revealed that the vast majority of marital partners (93%) were completely independent in performing activities of daily living. Of the total sample, only nine men and eight women required assis-

Table 3

Summary of the Background Characteristics of the Sample

Variables	Mean	S.D.	Range	Median
Men's age (N=135)	72.9	5.8	65-90	71
Women's age (N=135)	70.6	5.5	65-93	70
Men's years of education (N=135)	9.6	4.4	3-22	9
Women's years of education (N=135)	8.5	3.4	2-19	9
Years married (N=270)	42.3	12.5	0-70	45
Number of children (N=270)	3.0	1.9	0-14	3

(Continued on next page)

(Table 3 continued)

Variable	n		%
	Men	Women	
Mother Tongue (N=270)			
1. French	113	113	83.7
2. English	22	22	16.3
Birth Place (N=270)			
1. In Montreal	57	76	49.3
2. Out of Montreal, in Quebec	45	38	30.7
3. Out of Quebec, in Canada	18	12	11.1
4. Out of Canada	15	9	8.9
Religion (N=270)			
1. Catholic	117	117	87.0
2. Protestant	17	17	12.3
3. Jewish	1	1	0.7

Variable	n	%
Occupation (N=135)		
1. Sales and Service	39	28.8
2. Technical	41	30.3
3. Clerical	19	14.0
4. Managerial	13	9.6
5. Professional	10	7.4
6. Other	12	9.5
Living Arrangement (N=135)		
1. House	54	40.0
2. Non-Subsidized Apartment	67	49.6
3. Subsidized Apartment (F.L.M.)	8	5.9
4. Housing Unit for the Elderly	6	4.4

tance to perform selected activities such as shopping for groceries or performing household tasks. With respect to their social network size, most partners had many close relatives, friends and neighbors (M=18). Of the total sample, only four husbands (1.5%) reported having no contacts, except for their spouse. The stressful events reported most often by the marital partners were a "feeling of slowing down" (74%), hearing failure (69.2%), change in sexual behavior (55.5%), eyesight failure (38.1%), and painful arthritis (34%).

Paired t-tests indicated that the level of stress was significantly different between husbands and wives ($t(134) = -1.9$, $p < .05$). Wives tended to perceive more stress than their husbands (M: 210.3 and 189.2). There were no differences between the functional ability level and the size of the social network of husbands and wives.

Relationship between Husband-Wife Data

The study variables were subjected to descriptive analyses. The means, standard deviations and range of scores for each study variable appear in Appendix L. The relationship between husbands' and wives' data was also examined for each [illegible]r variable. This step was important as multiple measures taken on the same unit of analysis (husband/wife for each couple) tend to be correlated and consequently deserve special treatment in the analysis (Schumm, Bar[illegible]es,

Bollman, Jurich & Milliken, 1985). Husband-wife data were examined using intraclass correlation coefficients and paired t-tests.

Conjugal Support

Conjugal support was conceptualized as having three dimensions: Perceived Availability or Enactment, Reciprocity and Conflict. These dimensions were measured by a modified version of the Interpersonal Relationship Inventory (Tilden, 1987). A high score on each dimension indicated high availability, reciprocity and conflict.

Comparison between husbands' and wives' data for conjugal support appear in Table 4. Results indicated significant but moderate correlation coefficients between husbands and wives. Significant differences between the mean scores of husbands and wives were also found. Husbands, more than wives, perceived greater availability and reciprocity of conjugal support less conflict in their support relationship with their spouse.

Family Coping Behaviours

Family coping behaviours were measured by the Family Crisis Oriented Personal Evaluation Scales (McCubbin et al., 1987). The instrument consisted of five subscales, three of which tapped the ways the family externally handles problems and two on the ways a family internally handles problems.

Table 4

Comparison Between Husbands and Wives for Conjugal Support

(a) Intraclass Coefficients of Correlation

Variable	Intraclass Coefficient of Correlation	p
Availability	.47	.0001
Reciprocity	.36	.0001
Conflict	.32	.0001

(b) Paired T-Tests on the Mean Differences Between Husbands and Wives

Variable	Mean Husbands (H)	Mean Wives (W)	Difference H-W	t	df	p
Availability and/or Enactment	52.1	48.0	4.0	4.5	134	.0001
Reciprocity	49.1	46.2	2.9	4.7	134	.0001
Conflict	25.9	30.5	-4.6	-4.6	134	.0001

To describe the family coping behaviours of this sample of elderly marital partners, frequencies of use for each coping behaviour were calculated. All elderly partners reported using a variety of family strategies to cope with everyday problems or difficulties. The two strategies reported most often were seeking spiritual support (23%) and reframing (21.6%). Mobilizing the family to acquire and accept help (19.5%) was placed third in terms of its use by marital partners, followed by acquiring social support (18.2%). Passive appraisal or the ability of the couple to define the stressor as something that will take care of itself over time, was the family strategy elderly partners used least (17.7%).

To compare husbands' and wives' data, intraclass coefficients of correlation between husbands and wives and paired t-tests were computed for each of the five dimensions of family coping. As can be seen in Table 5, for two family coping strategies, "Mobilizing the Family to Acquire and Accept Help", and "Use of Passive Appraisal", the correlations between husbands and wives, were not significant. Wives, more than husbands, tended to perceive that their family made more use of Acquiring Social Support and Seeking Spiritual Support. The differences however were small (Table 5b). A description of family items for which the correlation coefficients between husbands and wives were equal or greater than .3 are presented in Table 6.

Table 5

Comparison Between Husbands and Wives for Family Coping

(a) Intraclass Coefficients of Correlation

Variable	Intraclass Coefficient of Correlation	p
Acquiring Social Support (ACSS)	.227	.008
Seeking Spiritual Support (SSP)	.495	.0001
Mobilizing Family to Acquire and Accept Help (MF)	.108	.213
Reframing (REF)	.358	.0001
Passive Appraisal (PA)	.023	.794

(b) Paired T-Tests on the Mean Differences Between Husbands and Wives

Variable	Mean Husbands (H)	Mean Wives (W)	Difference H-W	t	df	p
ACSS	19.2	21.9	-2.7	-3.5	134	.001
SSP	12.3	13.3	-1.0	-2.7	134	.007
MF	10.2	10.6	-.4	-.9	134	.332
REF	31.4	30.5	.9	1.4	134	.156
PA	13.9	13.6	.3	.5	134	.553

Table 6

Items of the F-Copes with Intraclass Coefficients of Correlation between Husbands and Wives >.3

Item #	Description of the item	Subscale	r*
10	"Asking neighbors for favors and assistance"	External Coping: Acquiring Social Support	.40
11	"Facing the problem "head-on" and trying to get solution right away"	Internal Coping: Reframing	.37
16	"Sharing Concerns with close friends"	External Coping: Acquiring Social Support	.32
18	"Exercising with friends to stay fit and reduce tension"	Stands alone as an item	.49
19	"Accepting that difficulties occur unexpectedly"	Internal Coping: Reframing	.34
21	"Seeking professional counselling and help for family difficulties"	External Coping: Mobilizing family to acquire and accept help	.46
30	"Having faith in God"	External Coping: Seeking Spiritual Support	.54

* For all coefficients, $p<.001$

Well-Being: Self-Assessed Health, Life Satisfaction, and Marital Satisfaction

Well-being was conceptualized as a multidimensional subjective phenomenon encompassing three related dimensions namely: (1) Positive Self-Assessed Health, (2) Life Satisfaction and (3) Marital Satisfaction. Self-Assessed Health was measured by the Cantril's self anchoring ladder (Cantril, 1965). The Life Satisfaction Index-Z (Wood et al., 1969) was used to measure Life Satisfaction and a visual analogue combined with an open-ended question measured Marital Satisfaction.

Comparisons between husbands and wives data appear in Table 7. The intraclass coefficients of correlation between husbands and wives demonstrated that the scores of husbands and wives on the three measures of well-being were significantly correlated. The correlation coefficients however were relatively low. Paired t-test revealed that husbands and wives differed significantly on their assessment of marital satisfaction, with husbands assessing their marital satisfaction higher than their wives. Both partners had similar perceptions of their health and life satisfaction.

Finally, each partner was asked two open-ended questions in relation to their perception of health and marital satisfaction. Responses in the first thirty interviews were reviewed and employing qualitative analysis, categories of responses were generated from the data by the

Table 7

Comparison Between Husbands and Wives for Well-Being

(a) Intraclass Coefficients of Correlation

Variable	r	p
Self-Assessed Health	.33	.0001
Life Satisfaction	.36	.0001
Marital Satisfaction	.38	.0001

(b) Paired T-Tests on the Mean Differences Between Husbands and Wives

Variable	Mean Husbands (H)	Mean Wives (W)	Difference H-W	t	df	p
Self-Assessed Health	7.62	7.63	-.01	-.07	134	.98
Life Satisfaction	18.63	18.50	.13	.25	134	.93
Marital Satisfaction	80.74	70.17	10.57	4.71	134	.001

researcher and a research assistant. The data from the total sample of husbands and wives were then coded independently by the researcher and a research assistant into categories. The initial inter-rater agreement (number of instances with agreement/total number of instances) was 95% for the health data and 87% for the marital satisfaction data. Tables 8 and 9 show the categories of response and their frequency counts for husbands' and wives' perception of indicators of health and marital satisfaction.

As indicated in Table 8, the main indicators of health were fairly similar for husbands and wives and were strongly related to mobility. "To Move Around and Be Able to Perform Activities of Daily Living" was found to be the most frequent indicator of health for both husbands and wives. However, "To Have Projects and Control Over Them" was expressed most often by husbands while "To be Loved" and "To be Able to Help Others" were expressed most often by wives as indicators of health.

"Instrumental Support" was the factor most frequently expressed as contributing to marital satisfaction in this elderly sample (Table 9). In general, husbands' and wives' perception of indicators of marital satisfaction were different. "Instrumental Support" and "Togetherness" were the factors reported most often by husbands while the "Good Understanding", "Sharing the Same Interests" and "Respect of Autonomy and Privacy" were stated most often by wives as

Table 8

Indicators of Health for the Elderly Marital Partners

Categories	Nb. of Instances[a] Husbands (%)	Nb. of Instances[a] Wives (%)
To Move Around, Be Able to Perform Activities of Daily Living	112 (31.4)	111 (30.5)
To Be Mentally Alert	49 (13.7)	48 (13.2)
To be Free of Disease	40 (11.2)	40 (11.0)
To Have Projects and Control Over Them	40 (11.2)	29 (8.0)
To Be Able to Exercise (Physical Fitness)	33 (9.2)	29 (8.0)
To Be Loved	27 (7.5)	40 (11.0)
To Be Able to Help Others	22 (6.2)	35 (9.6)
To Accept Life as It Is	18 (5.1)	12 (3.2)
To Feel in Harmony Physically and Mentally	16 (4.5)	20 (5.5)
Total	**357 (100%)**	**364 (100%)**

[a]Number exceeds total number of subjects as many partners cited more than one instance

Table 9

Indicators of Marital Satisfaction for the Elderly Marital Partners

Categories	Nb of Instances[a] Husbands (%)	Nb of Instances[a] Wives (%)
Instrumental Support Between Partners (assistance, help)	100 (39.5)	51 (17.2)
Togetherness (not being alone)	69 (27.3)	47 (15.9)
Good Understanding	33 (13.0)	99 (33.4)
Respect of Autonomy and Privacy	29 (11.5)	50 (16.9)
Sharing the Same Interests	22 (8.7)	49 (16.6)
Total	**253 (100%)**	**296 (100%)**

[a] Number exceeds total number of subjects as many partners cited more than one instance.

the important factors explaining marital satisfaction.

The Relationship Between the Study Variables

The data were analyzed to answer the three major research questions and to test related hypotheses. The questions addressed were:

(1) What is the relationship between the positive and negative aspects of conjugal support and the well-being of elderly marital partners?

(2) What family coping behaviours are related to the well-being of elderly marital partners?

(3) To what extent is the well-being of elderly marital partners associated with the characteristics of conjugal support (positive and negative) and family coping behaviours?

In the following sections, each of the research questions will be addressed in terms of individual data as well as couple data.

The Relationship Between Conjugal Support and the Well-being of Elderly Marital Partners

The first research question concerned the relationship between the positive and negative dimensions of conjugal support and the well-being of elderly marital partners. Two hypotheses were formulated: (1) there is a significant positive relationship between the positive dimensions of conjugal support (i.e. Availability/Enactment and Reciprocity) and the well-being of elderly marital partners and, (2) there is a significant negative relationship between the negative side of conjugal support (i.e. Conflict) and the well-being of elderly marital partners. Individual data were analyzed using zero-order correlation coefficients and Fisher's Zr transformations to compare the magnitude of the various correlation coefficients (Ferguson, 1981). Because gender differences have been shown with regard to the perception of conjugal support, individual data were considered according to gender. As husbands' and wives' data on these variables were correlated, couple-data were analyzed using a mixed design analysis of variance with husband/wife as a repeated measure (Schumm et al., 1985).

Analyses of individual data.

Analyses were carried out separately by gender. For men and women, zero-order correlation coefficients between the three dimensions of conjugal support i.e Availability/ Enactment, Reciprocity, and Conflict and the three dimensions of

well-being namely, Self-Assessed Health, Life Satisfaction, and Marital Satisfaction were calculated (Table 10). For both men and women, a significant positive relationship between the three dimensions of well-being and the perceived availability /enactment of conjugal support was found ($p<.001$). A significant positive relationship between the well-being of each marital partner and the perceiv ` reciprocity of conjugal support also was found ($p<.001$), as well as a significant negative relationship between the well-being of the elderly marital partner and the perception of conflict within the conjugal relationship ($p<.001$).

The significance of the differences between the correlation coefficients of men and women were tested using Fisher's Zr transformation. No significant differences were found between the coefficients of men and women ($Z < 1.96$ for all comparisons).

The strength of the correlations between each conjugal support dimension and each well-being criterion were also compared using Fisher's Zr transformation. For both men and women, the strength of the correlations between the three dimensions of conjugal support and marital satisfaction was significantly greater than the strength of the correlations between these dimensions and life satisfaction or self-assessed health ($1.96< Z < 2.58$, $p<.05$). The strength of the correlations between conflict, as a negative aspect of conjugal support, and the three measures of well-being, were not sig-

Table 10

Pearson's Correlation Coefficients Between Well-Being and Conjugal Support ; By Gender

(a) **Self-Assessed Health**

Conjugal Support	Men (n=135)	Women (n=135)
Availability/ Enactment	.28*	.30*
Reciprocity	.34*	.32*
Conflict	-.20*	-.21*

(b) **Life Satisfaction**

Conjugal Support	Men	Women
Availability/ Enactment	.46*	.55*
Reciprocity	.51*	.62*
Conflict	-.34*	-.36*

(c) **Marital Satisfaction**

Conjugal Support	Men	Women
Availability/ Enactment	.74*	.77*
Reciprocity	.68*	.74*
Conflict	-.71*	-.62*

*p<.001.

nificantly different than the strength of the correlations between the positive dimensions of conjugal support (availability/enactment and reciprocity) and the three well-being criteria for men and women ($Z<1.96$).

Analyses of couple data.

The relationship between conjugal support and well-being was also considered using the "couple" as the unit of analysis. Two analysis questions were addressed:

(1) Does the level of positive conjugal support, within-couple, have an effect on the well-being of the elderly couple?

(2) Does the level of negative conjugal support, within-couple, have an effect on the well-being of the elderly couple?

To answer these questions, two "couple variables" were created, namely "level of positive conjugal support " and "level of negative conjugal support". For each question, the sample (N=135 couples) was divided into three subgroups according to levels of positive conjugal support or negative conjugal support (high[H]-medium[M]-low[L]).

A couple was assumed to have a high level of positive conjugal support when high scores (scores >= M + 1SD) were obtained from both marital partners on the dimensions of Availability/Enactment and Reciprocity of conjugal support. Similarly, a couple was assumed to have a high level of negative conjugal support when high scores were obtained from

both marital partners on the Conflict subscale. A couple was assumed to have a medium level of positive conjugal support or conflict when the scores obtained from both marital partners on these dimensions were in the following range: M -1SD < score < M + 1SD. Finally, a couple was assumed to have a low level of positive conjugal support or conflict when low scores (<= M - 1SD) were obtained from both marital partners on these dimensions. When the score of only one spouse was in the foregoing ranges, the couple was discarded from the analyses and consequently the sample size was reduced.

For each question, a mixed design multivariate analysis of variance (2-way MANOVA) was performed with levels of positive or negative conjugal support (H-M-L) as the independent groups factor (between-couple factor) and spouse (husbands(H)-wives(W)) as the repeated measure (within-couple factor). The dependent variables were the three well-being measures (self-assessed health, life satisfaction and marital satisfaction).

The approximate multivariate F statistic was based on Wilks' Lambda. Significant multivariate effects were examined for univariate significance using analyses of variance (ANOVA's) for each well-being criterion (self-assessed health, life satisfaction and marital satisfaction). Significant univariate effects were further examined using Scheffe's post-hoc tests. Schumm and colleagues (1985) and Ball, McKenry and Bonham (1983) suggest this approach to analyse family data. Of

particular interest are the main effect of the independent groups factor, the means of which describe differences due only to the level of independent groups factor averaged over the couple, and the interaction effect of the independent groups factor and spouse which examines the differential impact of the independent groups factor on each spouse.

For the first question (i.e. "Does the level of positive conjugal support, within-couple, have an effect on the well-being of the elderly couple?"), the sample size was 76 couples. Results of the MANOVA performed on the three well-being criteria revealed a significant multivariate effect of positive conjugal support (group effect) on couples' well-being. This effect was qualified by a significant interaction effect between positive conjugal support and spouse, meaning that the effect of positive conjugal support had a differential impact on husbands' and wives' well-being (Table 11).

These significant effects were examined further using ANOVA's for each well-being criterion. A significant main effect of positive conjugal support was found for self-assessed health (F (2,73) = 5.82, $p<.005$). Scheffe's post-hoc test (Scheffe: $p<.05$) revealed that the low conjugal support group differed significantly from the medium and the high conjugal support groups. More specifically, couples from this group rated their health significantly lower (m=5.5) than couples from the medium (m=7.8) and the high level groups (m=7.4).

Table 11

Multivariate Analysis of Variance

Effects of Positive Conjugal Support on Couples' Well-Being

(N=76 Couples)

Test For Between-Couple Effect

Source	SS	df	MS	F	p
Positive Conjugal Support Group (H-M-L)	20381.7	2	10190.8	84.9	<.001
Error	8756.3	73	119.9		

Multivariate Test For Within-Couple Effects

Source	Criterion (Wilks'Lambda)	F	p
Spouse	.05	230.0	<.001
Spouse X Group	.23	14.7	<.001

A significant main effect of positive conjugal support was found also for life satisfaction ($F(2,73) = 13.43$, $p<.001$). The Scheffe's test showed that couples from the low conjugal support group rated their life satisfaction significantly lower ($m=11.1$) than those from the medium ($m=19.1$) and the high level groups ($m=20.5$).

The final analysis revealed a significant main effect of positive conjugal support for marital satisfaction ($F(2,73) = 99.27$, $p<.001$) qualified by an interaction effect between positive conjugal support and spouse ($F(2,73) = 3.25$, $p=.05$). Scheffe's tests showed that couples from the low group rated their marital satisfaction significantly lower than those from the medium and the high groups (Table 12a). The differences between husbands' and wives' means in the three groups are illustrated in Table 12b. Husbands in the low and medium groups rated their marital satisfaction significantly higher than their wives.

In summary, the level of positive conjugal support was found to have a significant effect on couples' well-being, qualified by a significant interaction effect between positive conjugal support and spouse. The multivariate main effect of positive conjugal support was attributed to univariate effects for couples' self-assessed health, life satisfaction and marital satisfaction. The significant multivariate interaction effect between positive conjugal support and spouse was attributed to a differential spousal impact of positive

Table 12

Multiple Comparisons of Marital Satisfaction Means Between High, Medium and Low Groups of Positive Conjugal Support Using Scheffe's Test

a) Comparison Between Couples' Marital Satisfaction Means

Conjugal Support Group	N	Couples' Marital Satisfaction Mean
High	11	91.4
Medium	59	80.9
Low	6	18.6

* Significant Difference Between Means at $p < .05$

b) Comparison Between Husbands' and Wives' Marital Satisfaction Means

Conjugal Support Group	Husbands' Marital Satisfaction Mean	Wives' Marital Satisfaction Mean
High	93.3	89.6
Medium	85.0	76.8
Low	25.3	12.0

* Significant Difference Between Means at $p < .05$

conjugal support on marital satisfaction.

The second question (i.e. "Does the level of negative conjugal support, within-couple, have an effect on the well-being of the elderly couple?) was answered through the same steps as the foregoing question. The sample (N=135 couples) was divided into three subgroups according to levels of conflict (H-M-L) in the conjugal support relationship. These three groups were considered as an independent groups factor in a mixed design analysis of variance with husband/wife as a repeated measure. The sample size used to perform the analyses was 77 couples.

As for the foregoing question, a MANOVA was performed first on the three measures of Well-Being (self-assessed health, life satisfaction and marital satisfaction). Results of the MANOVA revealed a significant main effect of conflict on couples' well-being qualified by an interaction effect between conflict and spouse (Table 13).

ANOVA's were then performed and revealed that conflict had no significant main effect for self-assessed health ($F(2,74) = 2.25$, $p=.11$). A significant main effect of conflict was found, however, for life satisfaction ($F(2,74) = 5.9$, $p=.004$). Post-hoc tests revealed that couples from the high conflict group rated their life satisfaction significantly lower ($m=13.9$) than couples from the medium ($m=19.3$) and low conflict groups ($m=18.6$). Finally, a significant main effect of conflict was found for marital satisfaction ($F(2,74) = 36.3$,

Table 13

Multivariate Analysis of Variance

Effects of Conflict in the Conjugal Support Relationship on Couples' Well-Being (N=77 Couples)

Test For Between-Couple Effect

Source	SS	df	MS	F	p
Conflict Group (H-M-L)	11516.9	2	5780.9	31.1	<.001
Error	13727.7	74	185.5		

Multivariate Test For Within-Couple Effects

Source	Criterion Wilks' Lambda	F	p
Spouse	.07	161.7	<.001
Spouse X Group	.45	6.7	<.001

$p<.001$), qualified by an interaction effect between conflict and spouse ($F(2,74) = 3.38$, $p=.05$). Post-hoc tests revealed significant differences between the three conflict groups for marital satisfaction (Table 14a). Husbands from the high conflict group rated their marital satisfaction significantly higher than their wives (Table 14b).

Results of the foregoing analyses support the relationship between the negative aspect of conjugal support, namely conflict, and well-being. More specifically, the level of conflict, within-couples, was found to have a significant effect on couples' life satisfaction and marital satisfaction and no significant effect on couples' self assessed health. Couples from the low conflict group were significantly more satisfied with their lives than couples from the medium or high conflict groups. Marital satisfaction of couples were significantly different in the three conflict groups. Husbands were found to be significantly more satisfied with their marital life than their wives in the high conflict group.

The foregoing analyses were performed on subsamples of couples, i.e. on couples congruent in their perception of positive or negative conjugal support. However, it is not clear if congruency of perception of conjugal support between husbands and wives is related to the couples' well-being. This question may be important in understanding the mechanism by which social support operates. Therefore, an additional analysis question was posed using couple data: "Does congruency

Table 14

Multiple Comparisons of Marital Satisfaction Means Between High, Medium and Low Conflict Groups Using Scheffe's Test.

a) Comparison Between Couples' Marital Satisfaction Means

Conflict Group	N	Couples' Marital Satisfaction Mean
High	7	36.5
Medium	62	77.6
Low	8	94.5

* Significant Difference Between Means at $p < .05$

b) Comparison Between Husbands' and Wives' Marital Satisfaction Means

Conflict Group	Husbands' Marital Satisfaction Mean	Wives' Marital Satisfaction Mean
High	45.8	27.2
Medium	79.3	75.9
Low	94.7	94.3

* Significant Difference Between Means at $p < .05$

between husbands' and wives' perception of conjugal support (positive and negative aspects) have an effect on the well-being of the elderly couple?"

The sample (N= 135 couples) was divided into congruent and non congruent couples. A couple was considered a "congruent couple" if the discrepancy between spouses' perceptions on positive conjugal support and conflict was less than or equal to one standard deviation (<=1S.D.). A couple was considered a "non congruent couple" if the discrepancy was greater than one standard deviation (>1S.D.).

The effect of congruency was examined using the same strategy as for the foregoing question. First, a 2-way mixed design MANOVA with Congruency/Non Congruency, as the independent groups factor and Husband/Wife as the repeated measure was performed on the three measures of well-being. Results showed a significant multivariate main effect of the Congruency factor on couples' well-being, qualified by a significant interaction effect with spouse, meaning that congruency impacted differently on husbands' and wives' well-being (Table 15).

To further explore these effects, ANOVA's were performed on each well-being criterion. Congruency was found to have no effect for self-assessed health ($F(1,133) = .03$, $p=.85$) and life satisfaction ($F(1,133) = 1.64$, $p=.20$). However, a significant interaction effect between congruency and spouse was found for life satisfaction($F(1,133) = 8.85$, $p=.003$).Scheffe's post-hoc test revealed that the effect of congruency was sig-

Table 15

Multivariate Analysis of Variance

Effects of Congruency Between Husbands' and Wives'Perception of Conjugal Support on Couples'Well-Being (N=135 Couples)

Test For "Between-Couple" Effects

Source	SS	df	MS	F	p
Congruency/ Non Congruency of Conjugal Support(CS)	1659.4	1	1659.4	5.1	.02
Error	42451.2	133	324.0		

Multivariate Test For" Within-Couple" Effects

Effects	Criterion (Wilks'Lambda)	F	p
Spouse	.05	435.3	.0001
Spouse X CS	.82	5.2	.0008

nificant only for wives. Wives from congruent couples rated their life satisfaction significantly higher ($\underline{m}$=19.9) than wives from non congruent couples ($\underline{m}$=16.9). There was no significant difference for husbands ($\underline{m}$=18.4 and 18.9). Within non congruent couples, husbands were found to be more satisfied with their lives than their wives ($\underline{m}$=18.9 and 16.9).

Finally, a significant main effect of congruency was found for marital satisfaction ($\underline{F}(1,133) = 5.90$, $\underline{p}$=.01), qualified by a significant interaction effect with spouse ($\underline{F}(1,333) = 21.07$, $\underline{p}<.001$). Scheffe's test revealed that the effect of congruency again was significant only for wives, with the marital satisfaction mean of wives from congruent couples significantly higher ($\underline{m}$=76.4) than the marital satisfaction means of wives from non congruent couples ($\underline{m}$=58.7). There was no significant difference for husbands ($\underline{m}$=79.7 and 82.5). Husbands were found to be more satisfied with their marital life than wives in the non congruent groups ($\underline{m}$=82.5 and 58.7).

In summary, congruency of perception between husbands and wives on conjugal support (positive and negative aspects) was found to have a differential spousal impact on life satisfaction and marital satisfaction. The effect of congruency was significant only for wives' life satisfaction and marital satisfaction.

The Relationship Between Family Coping Behaviours and the Well-Being of Elderly Marital Partners

The second question addressed was: "What family coping behaviours are related to the well-being of elderly marital partners?" To answer this question, individual and couple data were considered. Because gender differences were found in relation to the perception of selected family coping behaviours, individual data were analyzed per gender using zero-order correlation coefficients and Fisher's Zr transformations to compare the magnitude of the various correlation coefficients (Ferguson, 1981). As husbands-wives data were correlated for selected dimensions of family coping, couple-data were analyzed using a mixed design analysis of variance with husband/wife as a repeated measure (Schumm et al. 1985).

Analyses of individual data.

Pearson's correlation coefficients between the three well-being criteria (self-assessed health, life satisfaction and marital satisfaction) and each family coping behaviour, namely each internal family coping behaviour (reframing and passive appraisal) and each external family coping behaviour (acquiring social support, seeking spiritual support, and mobilizing the family to acquire and accept help) are presented according to gender in Table 16. As noted in the description of the F-Copes, items in the passive appraisal subscale were reversed when scoring. Therefore, a high score on passive appraisal denotes low use of the strategy and conversely a low score

Table 16

Pearson's Correlation Coefficients between Well-Being and Family Coping Behaviours; By Gender

a) **Self-Assessed Health**

Family Coping Behaviours	Men (n=135)	Women (n=135)
Internal Strategies		
Reframing	.48**	.50**
Passive Appraisal (avoidance)	.29**	.22**
External Strategies		
Acquiring Social Support	.01	-.05
Seeking Spiritual Support	-.04	.11
Mobilizing the Family to Acquire and accept help	-.11	-.04

*p<.05. **p<.01 (Continued on next page)

(Continued)
Pearson's Correlation Coefficients between Well-Being and Family Coping Behaviours; By Gender

b) Life Satisfaction

Family Coping Behaviours	Men	Women
Internal Strategies		
Reframing	.73**	.71**
Passive Appraisal (avoidance)	.30**	.48**
External Strategies		
Acquiring Social Support	.20*	-.03
Seeking Spiritual Support	.01	.16
Mobilizing the Family to Acquire and accept help	-.07	-.08

c) Marital Satisfaction

Family Coping Behaviours	Men	Women
Internal Strategies		
Reframing	.43**	.64**
Passive Appraisal (avoidance)	.35**	.21*
External Strategies		
Acquiring Social Support	.13	-.06
Seeking Spiritual Support	.08	.15
Mobilizing the Family to Acquire and accept help	.002	-.09

*p<.05. **p<.01

denotes high use of the strategy.

Results revealed a significant positive relationship between the use of internal family coping behaviours and the well-being of the elderly marital partners, both male and female. Reframing and "avoiding" passive appraisal were the two strategies that were significantly and positively related to self-assessed health, life satisfaction and marital satisfaction of the elderly marital partners. No significant relationship was found between the use of any of the external family coping behaviours and the well-being of the elderly marital partners except for "acquiring social support" which was significantly and positively related to the life satisfaction of men. The correlation coefficient however was small(r= .20).

The differences between the correlation coefficients of men and women was tested using Fisher's Zr transformation. No significant differences between the correlation coefficients were found ($Z < 1.96$).

Analyses of couple data.

Because coping was conceptualized in the present study as a family variable, analysis of couple data with regard to the relationship between family coping behaviours and well-being was deemed important. Internal family coping behaviours, namely reframing and passive appraisal, were chosen among other family coping behaviours for further analyses because they were the only behaviours found to be significantly related to the well-

being of both marital partners. The questions addressed were:

(1) Does the level of use of internal family coping behaviours, within-couple, have an effect on the well-being of the elderly couple?

(2) Does congruency between husbands' and wives' perception of their use of internal family coping behaviours have an effect on the well-being of the elderly couple?

To answer these two questions, the couple was considered as the unit of analysis. For the first question, the sample again was divided into three subgroups (high [H], medium [M] and low [L] use of internal family coping behaviours) using the same criteria as for the previous analyses. A 2-way MANOVA with the three groups (H-M-L) as the independent groups factor, husband-wife as the repeated measure, and the three well-being criteria as the dependent variables was performed followed by ANOVA's on each well-being criterion and Scheffe's post-hoc tests. A sample of 74 couples was used to perform the analyses.

The MANOVA revealed a significant multivariate main effect of internal family coping behaviours (group effect) on couples' well-being qualified by an interaction effect with spouse, meaning that the use of internal family coping impacted differently on husbands' and wives' well-being (Table 17).

ANOVA's on each well-being criterion showed that the use of internal family coping behaviours had a significant main effect for self-assessed health ($F(2,71) = 26.24$, $p<.001$).

Table 17

Multivariate Analysis of Variance

Effects of Internal Family Coping Behaviours on Couples' Well-Being (N=74 Couples)

Test For Between-Couple Effect

Source	SS	df	MS	F	p
Internal Coping Behaviours Groups (H-M-L)	9950.6	2	4975.3	26.6	<.001
Error	13272.8	71	186.9		

Multivariate Test For" Within-Couple" Effects

Effects	Criterion Wilks'Lambda	F	p
Spouse	.04	297.8	<.001
Spouse X Group	.44	6.7	<.001

Scheffe's post-hoc test revealed that only the low group differed from the others. Couples using a low level of internal family coping behaviours rated their health significantly lower ($\underline{m}$=4.6) than couples from the medium ($\underline{m}$=7.8) and the high ($\underline{m}$= 8.7) groups. A significant main effect of internal coping behaviours was also found for life satisfaction ($\underline{F}(2,71)$ = 60.39, $\underline{p}<.001$). Couples from the low level of internal coping rated their life satisfaction significantly lower ($\underline{m}$=10.4) than couples from the medium ($\underline{m}$=19.5) or high groups ($\underline{m}$=22.6).

Finally, the level of use of internal family coping behaviours was found to have a significant main effect for marital satisfaction ($\underline{F}(2,71)$ = 13.8, $\underline{p}<.001$). This effect was qualified by a significant interaction effect with spouse ($\underline{F}(2,71)$ = 6.22, $\underline{p}$=.01). The differences among the groups are presented in Table 18. The marital satisfaction means of husbands and wives from the group using a low level of internal family coping behaviours were significantly lower than those of the medium and high levels of internal family coping. Husbands rated their marital satisfaction significantly higher than their wives in the low and medium groups.

In summary, the foregoing analyses support the relationship found on individual data between the use of internal family coping behaviours and well-being. The use of internal family coping behaviours was found to have a multivariate main effect on couples' well-being. This effect was attributed to univariate effects for couples' self-assessed health, life

Table 18

Multiple Comparisons of Marital Satisfaction Means Between High, Medium and Low Groups of Internal Family Coping Using Scheffe's Test.

a) Comparison Between Couples' Marital Satisfaction Means

Internal Coping Group	N	Couples' Marital Satisfaction Mean
High	15	87.90
Medium	51	77.45
Low	8	51.15

* Significant Difference Between Means at $p < .05$

b) Comparison Between Husbands' and Wives' Satisfaction Means

Internal Coping Group	Husbands' Marital Satisfaction Mean	Wives' Marital Satisfaction Mean
High	88.8	87.0
Medium	81.0	73.9
Low	61.5	40.8

* Significant Difference Between Means at $p < .05$

satisfaction and marital satisfaction. Couples from the low group assessed their health significantly lower and were significantly less satisfied with their life and their marriage than couples from the medium and the high groups. Husbands from the medium and the low groups were significantly more satisfied with their marriage than their wives.

For the second question (i.e. "Does congruency of husbands' and wives' perception of their use of internal family coping behaviours have an effect on the well-being of the elderly couple?"), the sample (N=135 couples) was divided into two groups, congruent and non congruent couples, according to the criterion described earlier. A MANOVA with Congruency/Non Congruency as an independent groups factor, husbands/wives as a repeated measure, and the three well-being criteria as the dependent variables was followed by ANOVA's on each well-being criterion.

Results of the MANOVA revealed a significant main effect of congruency in the perception of use of internal coping behaviours for couples' well-being qualified by a significant interaction effect between congruency and spouse (Table 19).

ANOVA's revealed a significant main effect of congruency for self-assessed health ($F(1,133) = 4.37$, $p=.03$), qualified by an interaction effect with spouse ($F(1,133) = 5.46$, $p=.02$). Scheffe's tests showed that congruency in the couples' perception of their use of internal family coping only had a significant effect on self-assessed health of wives. Wives from

Table 19

Multivariate Analysis of Variance

Effects of Congruency Between Husbands' and Wives'

Perception of Use of Internal Family Coping on Couples'

Well-Being (N=135 Couples)

Test For "Between-Couple" Effects

Source	SS	df	MS	F	p
Congruency/ Non Congruency on Coping (C)	5527.5	1	5527.5	17.6	<.001
Error	41123.6	133	313.9		

Multivariate Test For "Within-Couple" Effects

Source	Criterion (wilk's Lambda)	F	p
Spouse	.04	515.3	<.001
Spouse X C	.79	6.5	<.001

congruent couples rated their health significantly higher (m=8.0) than wives from non congruent couples (m=7.0.) There was no significant difference for husbands (m=7.6 for both congruent and non congruent couples). A significant main effect of congruency was also found for life satisfaction (F(1,133) = 12.52, p<.001), qualified by a significant interaction effect with spouse (F(1,133) = 9.9, p=.002). Post-hoc tests showed only a significant effect of congruency on life satisfaction of wives, that is, wives from couples congruent in their perception of use of internal family coping behaviours rated their life satisfaction significantly greater (m=20.0) than wives from non congruent couples (m=15.8). There was no significant difference for husbands (m= 19.3 and 18.3).

The final ANOVA was performed with marital satisfaction as the dependent variable. A significant main effect of congruency was found (F(1,133) = 16.13, p < .001), qualified by an interaction effect with spouse (F(1,133) = 5.0, p=.02). Marital satisfaction means from congruent couples (m=80.2) was significantly greater than marital satisfaction means from non congruent couples (m=67.2). This pattern was consistent for both husbands and wives. However, within each group (congruent and non congruent couples), husbands' marital satisfaction mean scores were found to be significantly greater than their wives' mean scores (Table 20).

Table 20

Comparisons of Marital Satisfaction Means Between Congruent/Non Congruent Groups on Their Use of Internal Family Coping Behaviours.

a) Comparison Between Couples' Marital Satisfaction Means

Couples (group)	N	Couples' Marital Satisfaction Mean
Congruent on Internal Coping	85	80.2 *
Non Congruent on Internal Coping	50	67.2 *

* Significant Difference Between Means at $p < .05$

b) Comparison Between Husbands' and Wives' Marital Satisfaction Means

Couples (group)	Husbands' Marital Satisfaction Mean	Wives' Marital Satisfaction Mean
Congruent on Internal Coping	83.7 * *	76.8 *
Non Congruent on Internal Coping	75.6 *	58.9 *

* Significant Difference Between Means at $p < .05$

In summary, congruency between husbands and wives on perception of use of internal family coping behaviours was found to have a multivariate main effect on couples' well-being qualified by a significant interaction effect between congruency and spouse. The multivariate main effect was attributed to univariate effects for self-assessed health, life satisfaction and marital satisfaction. The significant multivariate interaction effect was attributed to a differential spousal impact on self-assessed health and life satisfaction. More specifically, congruency only had an effect on self-assessed health and life satisfaction of wives. It had an effect on marital satisfaction of both husbands and wives but husbands were more satisfied with their marriage than their wives in the two groups.

The Relationship between Conjugal Support, Family Coping Behaviours, and Well-Being

The third major issue addressed in the present study concerned the relationship between the three sets of variables: conjugal support, family coping behaviours, and the well-being of elderly marital partners. The question was:

> To what extent is well-being of elderly marital partners associated with the characteristics of conjugal support (positive and negative) and family coping behaviours?

The hypothesized model (Figure 1) implied two hypotheses: (1) conjugal support and family coping behaviours account for a significant part of the variance in the well-being of elderly

marital partners and, (2) conjugal support has a direct effect on the well-being of elderly marital partners and an indirect effect through family coping behaviours.

The question was answered primarily through multiple regression analyses. Because data from husbands and wives were correlated, they were considered separately, according to a major assumption underlying regression analysis (Pedhazur, 1982). As the concern of the present study was to determine the unique effects of family coping and conjugal support, hierarchical multiple regression analyses with control variables entered before the study variables were used to evaluate the amount of variance in well-being that could be explained by each of the study variables.

A series of hierarchical multiple regression analyses, one with each criterion variable, namely self-assessed health, life satisfaction, and marital satisfaction, were performed for husbands and wives separately. Control variables were entered into the regression equations followed by family coping variables and conjugal support variables because coping was hypothesized, according to previous studies, as an antecedent to conjugal support (See the hypothesized model in Figure 1).

The relative importance of each coping and support variable was examined using the standardized beta coefficients and the partial multiple correlations. To assess the indirect effect of conjugal support on well-being, the path from conjugal support to coping was determined by regressing family

coping variables on conjugal support variables. The level of significance for all tests was set at $p<.05$.

Preliminary analyses. Intercorrelation matrices for men and women (Appendix M) were first examined to identify control variables as well as to assess possible multicollinearity among the independent variables. The control variables were identified for each criterion variable, (self-assessed health, life satisfaction and marital satisfaction) as well as for men and women separately. To consider an extraneous variable as a control variable, this variable had to be significantly correlated with the dependent variable (either self-assessed health, life satisfaction or marital satisfaction) used in the multiple regression analysis. As a criterion for acceptance, the zero-order coefficient of correlation had to be at least .22 ($R^2=.05$).

Table 21 provides a summary of the control variables used in each regression equation. The correlation coefficients between "number of years married" and all the other variables in the correlation matrices were less than .22. Therefore, this variable was not considered as a control variable in the multiple regression analyses. The variable "source" was created to refer to the sampling source of either service users or non-service users and considered as a possible control variable in the regression analyses. Use of services was found to be positively correlated with self-assessed health and life sa-

Table 21

Summary of the Control Variables Used in Each Regression Analysis; By Gender

a) Criterion: Self-Assessed Health

Control Variables	r*	Control Variables	r*
Men		Women	
Functional Ability	-.53	Functional Ability	-.43
Level of Stress	-.40	Level of Stress	-.23
Source of sample	.27	Socioeconomic Status	.23

b) Criterion: Life Satisfaction

Control Variables	r*	Control Variables	r*
Men		Women	
Functional Ability	-.40	Functional Ability	-.34
Social Network Size	.34	Social Network Size	.32
Level of Stress	-.26	Level of Stress	-.22
Socioecomomic Status	.23	Socioeconomic Status	.22
Sample Source	.26		

c) Criterion: Marital Satisfaction

Control Variables	r*	Control Variables	r*
None	---	Social Network Size	.23

* All Correlation Coefficients Significant at $p<.01$

tisfaction for men. The control variables had no high correlations among themselves or with the other independent variables.

Correlation matrices for men and women were then examined to detect multicollinearity between independent variables. Subscales of the IPRI (Table 22) and of the F-Copes (Table 23) were examined first. Availability of conjugal support and reciprocity were highly correlated (r=.75 for men and women) and were combined (as suggested by Tilden, 1987) into one variable, namely "positive conjugal support" for all the regression analyses. Conflict in the conjugal relationship stood alone as an index of "negative support". The correlation coefficient between conflict and positive conjugal support was -.60 and -.62 for men and women respectively.

The correlations between all of the Internal Family Coping subscales of the F-Copes were significant as well as the correlations between all of the External Family Coping subscales. However, the coefficients were generally low except for reframing and passive appraisal which were moderately correlated. Thus, all coping variables were used as separate variables in the regression analyses.

The correlations between the subscales of the IPRI and the subscales of the F-Copes were also examined for multicollinearity (Appendix M). The correlations were found to be low or moderate. The highest correlation was between reframing and availability of conjugal support for women (r=.66). However, when availability and reciprocity were combined into positive

Table 22

Correlations between Subscales of the IPRI for Men and Women

a) **Men** (n=135)

	A	R	C
Availability (A)		.75*	-.70*
Reciprocity (R)			-.54*
Conflict(C)			

b) **Women** (n=135)

A		.75*	-.74*
R			-.53*
C			

*p<.01

Table 23

Correlations Between Subscales of the F-Copes for Men and Women

a) Men (n=135)

	R	PA	ASS	SSS	MF
Internal Coping/					
Reframing(R)		.49**	.21**	.03	-.06
Passive Appraisal(PA)			-.05	.11	-.06
External Coping/					
Acquiring Social Support(ASS)				.21*	.25**
Seeking Spiritual Support(SSS)					.18*
Mobilizing the Family to Acquire and Accept Help(MF)					

b) Women (n=135)

	R	PA	ASS	SSS	MF
Internal Coping/					
Reframing(R)		.30**	.20**	.00	.20**
Passive Appraisal(PA)			-.13	-.03	-.05
External Coping/					
Acquiring Social Support(ASS)				.18*	.35**
Seeking Spiritual Support(SSS)					.27**
Mobilizing the Family to Acquire and Accept Help (MF)					

*p<.05. **p<.01.

conjugal support, the correlation coefficient between reframing and this variable was reduced to .52.

Results of regression analyses. Regressions were performed with all the independent variables entered into the equation, i.e. all family coping variables (reframing, passive appraisal, acquiring social support, seeking spiritual support, and mobilizing the family to acquire and accept help) and conjugal support variables (positive conjugal support and conflict), as well as with a restricted number of variables, i.e. variables found to be significant in the bivariate analyses, namely, in their entering order, reframing, passive appraisal, positive conjugal support and conflict. Results from these two types of regression were the same (i.e. the same variables were found to be significant predictors of well-being). Therefore, regressions performed with a restricted number of variables (significant in bivariate analyses) will be presented in the following pages. In each analysis, reframing was entered before passive appraisal because of its higher correlation with the three well-being criteria. Positive conjugal support was entered before conflict for the same reason. Reframing and passive appraisal were entered before positive conjugal support and conflict because coping was hypothesized as an antecedent to conjugal support.

Results of regression analyses predicting self-assessed health for men and women are presented in Table 24. Beyond the control variables, only the use of reframing was found to account for a significant part of the variance in self-assessed health of men and women. It explained an additional 16% and 10% of the variance in self-assessed health of men and women respectively.

Results of multiple regressions predicting life satisfaction, as the well-being criterion, showed that beyond the control variables, reframing, passive appraisal and positive conjugal support were significant predictors of life satisfaction of both men and women (Table 25). Despite their significance, the contributions of passive appraisal and positive conjugal support were small. The use of reframing accounted, beyond the control variables, for 35% and 32% of the variance in life satisfaction of men and women respectively.

Marital satisfaction finally was used as the well-being criterion in multiple regression (Table 26). The use of reframing and positive conjugal support added significant increments to the variance of marital satisfaction of men and women. Positive conjugal support explained more variance in marital satisfaction of men than in marital satisfaction of women (35% and 23% respectively). In contrast, reframing was found to explain more variance in marital satisfaction of women than in marital satisfaction of men (R^2 change=.39 and .22 respectively). Conflict was found to explain a significant

Table 24

Hierarchical Multiple Regression Predicting Self-Assessed Health

a) **Men** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Control	.280					
Reframing	.441	.161	.09	.29	3.9	.0001
Passive Appraisal	.447	.006	.05	.08	1.1	.24
Positive Conjugal Support	.452	.005	.01	.08	1.0	.28
Conflict	.453	.001	-.01	-.04	-.4	.60

R^2=.45, F=14.9, p=.0001.

b) **Women** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Control	.280					
Reframing	.388	.108	.12	.40	5.4	.0001
Passive Appraisal	.401	.013	.08	.12	1.6	.09
Positive Conjugal Support	.404	.003	.01	.08	1.0	.28
Conflict	.406	.002	-.01	-.07	-.6	.49

R^2=.40, F=10.1, p=.0001.

Table 25

Hierarchical Multiple Regression Predicting Life Satisfaction

a) **Men** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Control	.24					
Reframing	.59	.35	.40	.47	6.3	.0001
Passive Appraisal	.61	.02	.23	.15	2.2	.025
Positive Conjugal Support	.63	.02	.06	.18	2.2	.026
Conflict	.633	.00	.02	.04	0.4	.610

R^2=.63, F=26.3, p=.0001.

b) **Women** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Control	.250					
Reframing	.573	.320	.32	.40	4.9	.0001
Passive Appraisal	.581	.008	.23	.13	2.2	.025
Positive Conjugal Support	.623	.042	.09	.32	3.2	.001
Conflict	.623	.000	.03	.05	0.7	.471

R^2=.62, F= 25.2, p=.0001.

Table 26

Hierarchical Multiple Regression Predicting Marital Satisfaction

a) **Men** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Reframing	.22		1.2	.42	4.8	.0001
Passive Appraisal	.25	.03	0.1	.02	0.3	.721
Positive Conjugal Support	.60	.35	0.6	.50	6.6	.0001
Conflict	.66	.06	-.7	-.36	-5.0	.0001

R^2=.66, F= 62.4, p=.0001.

b) **Women** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Control	.05					
Reframing	.44	.390	.58	.15	2.1	.03
Passive Appraisal	.447	.007	.34	.04	0.7	.45
Positive Conjugal Support	.68	.23	.85	.61	7.0	.0001
Conflict	.69	.01	-.28	-.11	-1.6	.10

R^2=.69, F=56.6, p=.0001.

amount of variance in marital satisfaction of men only.

To test the hypothesis of an indirect effect of conjugal support on well-being through family coping, each internal family coping variable (use of reframing and passive appraisal) was regressed on conjugal support (see the proposed model in Figure 1) for men and women separately. The internal family coping variables were chosen among other family coping behaviours because they were identified in previous analyses as significant predictors of well-being of elderly marital partners. Control variables were determined according to the same criterion as for other analyses. Table 27 presents the results of regressions of reframing on conjugal support for men and women. Beyond the control variables, positive conjugal support was found to be a significant predictor of reframing, accounting for 22% and 43% of the variance for men and women respectively. Results of regressions of passive appraisal on conjugal support appear in Table 28. For both men and women, the perception of conflict was a significant predictor of passive appraisal accounting for 14% and 6% of the variance respectively.

The final models.

The models for men and women appear in Figures 3 and 4 respectively. The path coefficients in the model are standardized partial regression coefficients which represent the effect of each independent variable on each dependent variable while holding the effects of all other variables

Table 27

Hierarchical Multiple Regression Predicting Reframing

a) **Men** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Control	.09					
Positive Conjugal Support	.31	.220	.14	.40	3.9	.0001
Conflict	.311	.001	-.06	-.08	-.8	.38

R^2=.31, F=15.1, p=.0001.

b) **Women** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Control	.05					
Positive Conjugal Support	.48	.43	.25	.69	7.8	.0001
Conflict	.48	.00	.03	.05	0.5	.56

R^2=.48, F=40.3, p=.0001.

Table 28

Hierarchical Multiple Regression Predicting Passive Appraisal

a) **Men** (n=135)

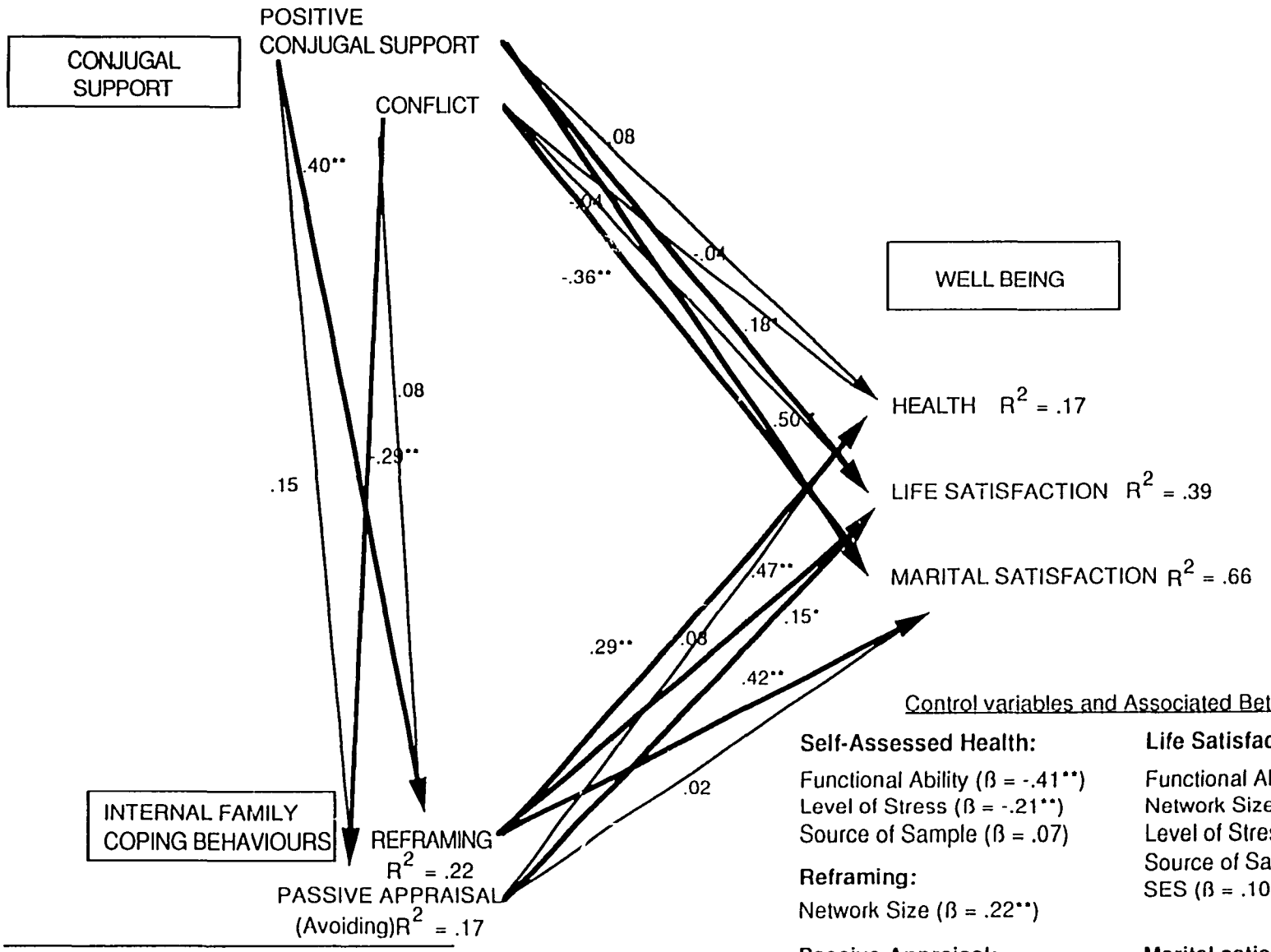
Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Positive Conjugal Support	.03		.15	.10	1.4	.54
Conflict	.17	.14	-.11	-.29	-2.7	.006

R^2=.17, F=13.8, p=.001

b) **Women** (n=135)

Variable	Model R^2	R^2 Change	b	B	t for H0: b=0	p At Last Step
Positive Conjugal Support	.01		.07	.62	0.1	.53
Conflict	.07	.06	-.09	-.30	-2.6	.009

R^2=.07, F=4.7, p=.009.



Control variables and Associated Beta Weights:

Self-Assessed Health:

Functional Ability (ß = -.41**)
Level of Stress (ß = -.21**)
Source of Sample (ß = .07)

Reframing:

Network Size (ß = .22**)

Passive Appraisal:

None

Life Satisfaction:

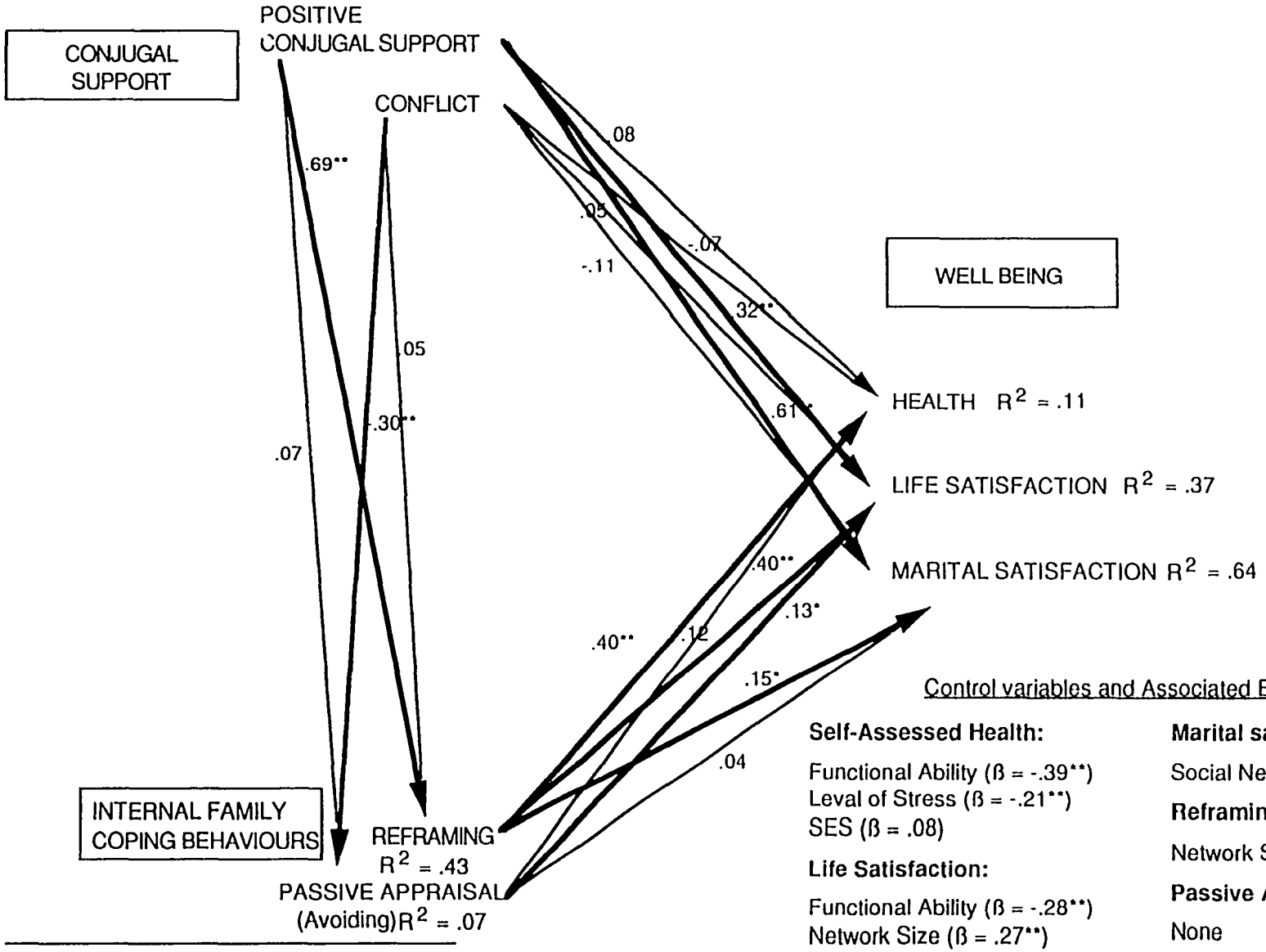
Functional Ability (ß = -.28**)
Network Size (ß = .26**)
Level of Stress (ß = -.16**)
Source of Sample (ß = .03)
SES (ß = .10*)

Marital satisfaction:

None

*p<.05, **p<.01

Figure 3 : Final Model for Men (n =135)



*p<.05, **p<.01

Figure 4 : Final Model for Women (n =135)

Control variables and Associated Beta Weights:

Self-Assessed Health:

Functional Ability (ß = -.39**)
Leval of Stress (ß = -.21**)
SES (ß = .08)

Life Satisfaction:

Functional Ability (ß = -.28**)
Network Size (ß = .27**)
Level of Stress (ß = -.15**)
SES (ß = .10*)

Marital satisfaction:

Social Network (ß = .22**)

Reframing:

Network Size (ß = .21**)

Passive Appraisal:

None

in the model constant.

The models for men and women appear fairly similar. They both support a significant indirect effect of positive conjugal support on self-assessed health, life satisfaction and marital satisfaction through reframing. This means that the perception of positive conjugal support leads to the use of reframing, an internal family coping behaviour, which in turn leads to a better perception of health, life and marital satisfaction. However, both models support only a significant direct effect of positive conjugal support on life satisfaction and marital Satisfaction (no direct effect on self-assessed health).

The negative side of conjugal support, namely conflict, was found to have a slightly different pattern for men and women. In both cases, it was found to have only an indirect effect on life satisfaction through the use of passive appraisal. This means that the perception of conflict in the conjugal relationship leads to the use of passive appraisal, an internal family coping behaviour, which in turn has a negative effect on life satisfaction of men and women. Conflict had no significant direct or indirect effect on self-assessed health. However, for men, it had a direct effect on marital satisfaction.

Analyses of Couple Data.

To examine the experience of the elderly couple, analysis questions pertaining to the relationship between conjugal support, family coping behaviours, and well-being were also considered. As the use of reframing and positive conjugal support were the most important predictors of spousal well-being, these two variables were considered simultaneously in couple data analysis. The first question addressed was:

> Does the use of reframing along with the perception of positive conjugal support have an effect on the couple's well-being?

To determine the unique effects of reframing and positive conjugal support, control variables were considered in the analysis. Therefore, a multivariate analysis of covariance (MANCOVA) was performed. The covariates were the extraneous variables that were significantly correlated (r >.22) with husbands' and wives' well-being criteria, i.e functional ability, level of stress, social network size and SES. Three subgroups of couples were used: those with high, medium, and low levels of both reframing and positive conjugal support. These three groups were considered in the MANCOVA as an independent groups factor, with husband/wife as a repeated measure.

The MANCOVA showed significant multivariate effects of both reframing ($F(2,36) = 5.05$, $p=.01$) and positive conjugal support ($F(2,36) = 42.9$, $p<.001$) on couples' well-being after adjusting for the covariates. Only reframing was found to have a significant main effect for self-assessed health ($F(2,36) = 9.2$, $p<.001$) and life satisfaction ($F(2,36) = 13.3$, $p<.001$). To the contrary, only positive conjugal support was found to have a main effect for marital satisfaction ($F(2,36) = 57.5$, $p<.001$).

The foregoing results emphasize the differences between the three well-being criteria. As was demonstrated with the individual data, reframing and positive conjugal support had a differential impact on self-assessed health, life satisfaction and marital satisfaction.

Because results of individual data analysis showed that conjugal support predicted family coping, more specifically, that positive conjugal support predicted reframing and that conflict predicted passive appraisal, two final questions were asked in relation to couple data:

(1) Does the level of positive conjugal support have an effect on the use of reframing within couples?

(2) Does the level of conflict have an effect on the use of passive appraisal within couples?

The analysis was similar for both questions. For the first question, couples were clustered into three levels of positive conjugal support (high[H], medium[M], low[L]), according to the criteria described earlier, and examined on reframing. For the second question, couples were grouped into three levels of Conflict (H-M-L) and passive appraisal was the dependent variable. Examination of the correlation matrices (Appendix M) revealed that no variable reached a level of relationship with the dependent variables necessary for them to be considered as covariates in the analyses.

Results of the ANOVA'S supported individual data analyses and showed that positive conjugal support had a significant main effect on reframing ($F(2,73) = 16.6$, $p<.001$) and that conflict had a significant main effect on passive appraisal ($F(2,98) = 4.1$, $p=.01$).

Summary of Findings

In this study, three research questions were answered and four related hypotheses were tested using a sample of 135 elderly couples living at home.

Analysis of the first research question which aimed to identify the relationship between the positive and negative aspects of conjugal support and the well-being of elderly marital partners supported the stated hypotheses at the .05 level of statistical significance:

(1) There was a significant positive relationship between the well-being of elderly marital partners and the positive aspects of conjugal support;

(2) There was a significant negative relationship between the well-being of elderly marital partners and the negative side of conjugal support.

Zero-order correlations showed that these relationships were significant for the three measures of well-being used in the study (i.e. self-assessed health, life satisfaction and marital satisfaction) and for men and women considered separately. There were no differences between the correlation coefficients of men and women. The correlations between the positive and negative aspects of conjugal support and marital satisfaction were significantly greater than the correlations between all aspects of conjugal support and self-assessed health or life satisfaction for

both men and women. The strength of the correlations between conflict and the three well-being criteria was not different than the strength of the correlations between the positive aspects of conjugal support (availability/enactment and reciprocity) and the three well-being criteria.

Multivariate analyses performed on couple data showed main effects of positive conjugal support and conflict on couples' well-being. Husbands from the low positive conjugal support and the high conflict groups were significantly more satisfied with their marriage than their wives.

Additional analysis on the effect of congruency between husbands' and wives' perceptions of conjugal support on well-being revealed that congruency had a differential effect on life satisfaction and marital satisfaction of husbands and wives. Wives from congruent couples were more satisfied with their life and their marriage than wives from non congruent couples while there were no differences for husbands.

Analysis of the second research question which aimed to identify the relationship between family coping and well-being revealed only a significant positive relationship between the use of internal family coping behaviours, i.e. reframing and avoidance of passive appraisal, and the well-being of both marital partners (self-assessed health, life satisfaction and marital satisfaction). There were no differences between the correlation coefficients of men and

women.

Analysis of couple data also revealed a significant effect of the use of internal family coping behaviours on couples' well-being. Further analyses showed that congruency between husbands and wives on their perception of use of internal family coping behaviours had effects only on self-assessed health and life satisfaction of wives. In both congruent and non congruent groups, husbands were found also to be significantly more satisfied with their marital life than their wives.

The third research question concerned the relationship between the three sets of variables: conjugal support, family coping, and the well-being of elderly marital partners and implied two hypotheses:

(1) Conjugal support along with family coping behaviours account for a significant part of the variance in the well-being of elderly marital partners;

(2) Conjugal support has a direct effect on the well-being of elderly marital partners and an indirect effect through family coping behaviours.

The hypothesized model of the relationship between the variables (Figure 1) was supported in part by selected well-being indicators and selected conjugal support and coping variables (Figures 3 and 4). Conjugal support (positive and negative aspects) did not account for a significant part of the variance in self-assessed health.

Only reframing was significantly associated with self-assessed health, explaining, beyond the control variables, 16% and 10% of the variance in self-assessed health of men and women respectively.

Reframing, avoidance of passive appraisal, and positive conjugal support were found to contribute significantly to life satisfaction of men and women. The use of reframing accounted for the major part of the variance explaining, beyond the control variables, 35% and 32% of the variance in life satisfaction of men and women respectively. Finally, both support and coping variables were found to account for a significant part of the variance in marital satisfaction. The patterns for men and women however were slightly different. Reframing, positive conjugal support and conflict added significant increments to the variance in marital satisfaction of men while for women only reframing and positive conjugal support explained significant parts of the variance. The perception of positive conjugal support explained more variance in marital satisfaction of men than women (R^2= .35 and .23) while the use of reframing explained more variance in marital satisfaction of women than of men (R^2=.39 and .22).

The indirect effect of conjugal support on well-being through family coping was supported also for selected well-being criteria. For both men and women, positive conjugal support had an indirect effect on the three well-being

criteria through the use of reframing while negative support (conflict) had only an indirect effect on life satisfaction through passive appraisal.

Analyses of couple data supported in part the foregoing results. Similar to the individual data, the effects of conjugal support and coping differed for the three well-being criteria. Reframing was found to have an effect on couples' self-assessed health and life satisfaction while positive conjugal support was found to have an effect on couples' marital satisfaction. As with the individual data, the level of positive conjugal support was found to have an effect on the couples' use of reframing while the level of conflict had an effect on the couples' use of passive appraisal

CHAPTER 5

DISCUSSION

The purpose of this study was to assess the relationships between conjugal support, family coping behaviours, and well-being of elderly marital partners living in the community. This chapter is divided into five major sections. First, characteristics and representativeness of the sample are discussed. The bivariate association between conjugal support and well-being indicators, as well as between family coping behaviours and well-being, are then addressed. A discussion of the model linking these variables follows. Methodological and theoretical issues related to family data are considered, concluding with implications for nursing practice and research.

Characteristics and Representativeness of the Sample

The sample appears comparable to the reported description of Canadian noninstitutionalized elderly (Gooding, Sloan & Amsel,1988; Statistics Canada, 1987), reflecting a relatively well elderly population. When compared with the labor force distribution among the elderly in Quebec (Bureau de la Statistique du Quebec, 1986) and in Canada (Statistics Canada, 1981), the sample also is reasonably representative of the population, i.e. the majority of the subjects had held positions in what are described by Statistics Canada

as either service, primary or processing occupations. This sample reflects the educational level, mother tongue and religious affiliation of the elderly population in Quebec (Bureau de la Statistique du Quebec, 1986).

The refusal rate in the present study (15.4%) may be explained by the time of data collection. As the study was carried out primarily during the summer period, refusing couples reported they were engaged in outside activities and too busy therefore to participate. These subjects were similar in terms of age, referral mechanisms and socio-economic status to those who took part in the study. However, the total number of couples that were screened out or refused, either in the service agencies or in the snowball sampling strategy, is unknown.

Conjugal Support and Well-Being

One of the questions directing this study concerned the bivariate relationship between conjugal support and the well-being of elderly marital partners. Findings supported the hypotheses proposing a significant positive relationship between the positive dimensions of conjugal support (perceived availability/enactment and reciprocity) and well-being for both elderly husbands and wives. Conflict, as hypothesized, was negatively related to the three measures of well-being.

The nature of the association between perceived support and well-being is still not well understood. No reports were found of studies addressing the relationship between the qualitative characteristics of conjugal support, positive and negative, and the well-being of the elderly marital partners. Some of the work which has examined the more general concept of "social support" and its relationship with the well-being of the elderly may provide some understanding of the study findings.

The significant positive relationship found in the present study between perceived availability/enactment of conjugal support and well-being, is consistent with the findings of Krause (1987) and Ward and colleagues (1984) that report a positive association between perceived social support and the well-being of the elderly. Recent literature suggests, however, that perceived availability of support is more important for well-being than support actually received (Mercer & Ferketich, 1988; Wethington & Kessler, 1986). The IPR used to measure the variable of conjugal support in the present study is based on a conceptualization of support in which perceived availability and enactment of support are undifferentiated. Consequently, at this point, it is impossible to discuss separately the relationship between perceived "availability" of conjugal support and well-being and perceived "enactment" of conjugal support and well-being.

The findings of this study suggest also that perceived reciprocity is an important component in understanding the relationship between conjugal support and well-being outcomes. As in the present study, a positive association was found between reciprocity and well-being in several studies on support and the elderly (Antonucci, 1985; Kahn & Antonucci, 1984; Minkler et al. 1983). More particularly, Antonucci (1985b) found that spousal reciprocity was associated with higher levels of happiness. Social exchange theory (Foa, 1971) has been used to explain such an association. According to exchange theory, the "exploiters" as well as the "victims" in an inequitable relationship are more distressed than they would be in an equitable one. Dependence even on family members can lower well-being. The explanation offered by DiMatteo and Hays (1981) is that unequal exchange or asymmetry may burden those supporting and undermine the recipient's sense of control.

The significant negative relationship between conflict and well-being found in the present study underscores the importance of considering the stress-producing aspects of support in research. The strength of the association between the positive aspects of conjugal support and indicators of well-being was not different than the strength of the association between conflict and well-being. Rook (1984), however, in one of the few studies in which both positive and negative aspects of social support of the aged

were considered simultaneously, reported a stronger association between conflict and well-being than between positive social support and well-being. Rook considered the impact of various sources of social support, measured by quantitative indicators such as the number of supportive and problematic social ties, on older widowed women's well-being. Therefore, the different conceptualization of support and different study population may account for the difference between Rook's findings and those of the present study. Rook, in explaining her findings reasoned that the lonely elderly (widowed) are more affected by problematic social ties than by supportive ties probably because they are less effective interpersonally than the nonlonely elderly.

One contribution of the present study relates to its treatment of well-being as a three dimensional, interrelated construct. A global measure (life satisfaction) and two more specific measures (marital satisfaction and self-assessed health) were used to assess well-being. One issue that must be addressed is that of the differing strengths found in the relationships between selected dimensions of conjugal support and well-being dimensions. More specifically, the positive and negative dimensions of conjugal support showed a stronger association with marital satisfaction than with life satisfaction or self-assessed health.

One explanation for such a finding is that the two variables, conjugal support and marital satisfaction, have a shared variance and thus conceptually may be similar. The qualitative indicators of marital satisfaction found in the present study (Table 9) suggest, however, that support is only one indicator, among others, of marital satisfaction. Thus, one can argue that the meanings of conjugal support and marital satisfaction are conceptually different. In the marriage literature, aspects of conjugal support, such as exchange of love and services and emotional support, are considered as being different from marital satisfaction and there is ample evidence for the strong relationship between conjugal support and marital satisfaction (Rettig & Bubolz, 1983).

Husband-Wife Patterns

Analyses revealed certain differences between husbands and wives concerning conjugal support. Both quantitative and qualitative data showed that husbands perceived more availability and reciprocity of conjugal support and less conflict in the conjugal relationship than their wives, a result consistent with previous research (Antonucci & Depner, 1982; Campbell et al., 1976; Stinnet et al.,1970). Moreover, in comparing scores on marital satisfaction between husbands and wives, husbands were more satisfied with their marital life than their wives. Despite these statistically significant differences in husbands' and

wives' scores, the clinical relevance of such differences remains unclear.

Data are available which indicate gender differences in both the nature and function of social support (Antonucci, 1985a; Antonucci & Akiyama, 1987; Depner & Ingersoll-Dayton, 1985). The different socialization processes of men and women might explain such differences in perception. More precisely, the social-emotional skills and the gender-role attributed to women may influence their assessment of the marital relationship. According to Antonucci (1985a), men maintain close and intimate ties with only one person, their spouse. Women, on the other hand, have more extensive and more varied networks and have maintained the role of kinship keeper possibly because of their traditional role as homemaker (Antonucci, 1985a). Men may perceive more positively their primary support, i.e conjugal support, while the multifaceted nature of women's support networks may be accompanied by increased expectations of their conjugal support and consequently less satisfaction.

Congruency between marital partners on their perception of positive and negative conjugal support was found to have an effect only on wives' well-being. In a previous study, Antonucci and Israel (1986) examined the impact of congruency of perception of social support in relation to the well-being of the elderly and found that congruency was not

related to well-being. These authors proposed that the individual's perception of support, might in some instances be more important than the mutual perceptions of support exchanges or congruency. Therefore, an interesting question raised by the present study findings is why congruency of perception appeared to have an effect only on wives' well-being? Results suggest that men are less sensitive to the quality of the relationship and are more self-centred, focusing on the beneficial aspects of conjugal support. In fact, the quality of social support has been found recently to have a greater impact on the well-being of women compared to men (Antonucci & Akiyama, 1987). More specifically, degree of closeness (Shulman, 1976), mutuality (Swanson & Maruta, 1980), and empathy (Gray, Brogan & Kutner, 1985), related to support congruency, might be the aspects of conjugal support which impact on the well-being of women. It is apparent that there is much that is not known about the qualitative dimensions of social support.

Family Coping Behaviours and Well-Being

A particular interest in the present study was to identify the family coping behaviours that relate to the well-being of elderly marital partners. Consistent with the literature, couples in the present study used a variety of coping strategies (Barush, 1988; Olson et al., 1983). However, only two internal family coping strategies, namely

the use of reframing and avoidance of passive appraisal, were positively related to the three well-being indicators of self-assessed health, life satisfaction and marital satisfaction. The external family coping behaviours used by the elderly couples were not found to be related to their well-being. Because no previous study has examined the association between family coping behaviours and the well-being of the elderly dyad, comparisons with previous works is not possible. However, various explanations might be provided for these results.

One such explanation is a methodological one. Unlike the majority of other studies which have looked at support or coping in the face of a particular stressful event, this study explored the variables within the context of everyday living. Under such circumstances, elderly couples may need less external support and therefore elderly partners may have underestimated their use of these sources of social support. People probably assess more reliably their use of coping behaviours during a crisis when a specific situation is experienced.

The self-report nature of the family coping and well-being instruments also may account for the findings. As these measures were obtained through an interview format, they may reflect a social desirability bias. That is, these couples may have wished to portray a picture of independence and health.

Nevertheless, despite these methodological concerns, there are reasons to believe that the study findings are valid. The two family coping strategies positively associated with well-being, reframing and avoidance of passive appraisal, are cognitive strategies (internal coping). According to McCubbin et al. (1987), reframing is the ability to redefine problematic situations in order to make them more manageable and passive appraisal involves denial of problems and a feeling of powerlessness.

The items of the Internal Family Coping subscales (Reframing and Passive Appraisal) would appear to reflect a sense of control which according to Baron and Rodin (1978), is defined as the ability to regulate or influence intended outcomes through selective responding. The need for mastery and control of one's environment has long been viewed as a basic human motivation and has been found to have profound effects on people's well-being (Clark, Levitt & Finley, 1984; Janis & Rodin, 1985; Levitt, Clark, Rotton & Finley, 1987), particularly with the aged (Rodin, 1986). Thus, family coping behaviours related to seeking external help, may imply a loss of control and dependency for this specific elderly population living at home and therefore may cancel its effect on well-being.

The apparent beneficial effect of working things out by oneself was pointed out by Pearlin et al. (1978). Other researchers (Husaini, Newbrough, Neff & Moore, 1982) have

suggested that the act of engaging in help seeking may be viewed as an indicator of underlying coping ineffectiveness or social incompetence or that help-seeking is a hallmark of the poor coper. Seeking help might imply that recipients are not responsible for solving a problem, thus reflecting an inequality of the exchange. Anticipation of difficulties in reciprocating may actually deter some people from seeking help when they need it (Greeberg & Shapiro, 1971; Riley & Eckenrode, 1986). In the North American culture, it is quite clear that it is better to give than to receive. Antonucci and Akiyama (1987) have speculated that this bias allows people to maintain their own personal sense of independence.

The finding that external coping behaviours are not related to well-being is in direct contrast to that reported in most studies on coping. Considerable support is offered for the positive effect of active strategies such as seeking external help and support on well-being (Billings et al., 1981, 1984; Felton et al., 1984; Kahana et al., 1987; McCrae et al., 1986). For example Pratt and colleagues (1985), using the same family coping questionnaire with a group of elderly caregivers, found that the use of spiritual support and extended family, were negatively related to the caregiver burden. Similarly, Felton et al. (1984) and Billings et al. (1984) found a salubrious effect of information seeking (an external family coping strategy) on the well-being of middle-aged and aged adults. These contradic-

tory findings may be explained possibly by the differing populations under study. In Pratt's (1985) research, a population of caregivers was studied. Felton et al. (1984) and Billings et al. (1984) studied clinical samples of chronically ill and depressed adults. A common characteristic of these samples is that they represent populations in need of help whereas the present study examined a non-clinical sample of elderly couples living independently in the community.

Another possible explanation for the findings may be the age of the subjects. In those studies using a developmental framework, elderly adults were found to be more internally controlled than adolescents and younger adults (Duke, Shaheen & Nowicki, 1974; Morganti, Nehrke, Hulicka & Cataldo, 1988; Neugarten, Havighurst & Tobin, 1968). Moreover, "internal" elderly individuals were found to be more satisfied with their life situation than "externals" (Felton & Kahana, 1974). Empirical evidence for the proposal that the strength of the relationship between internal control and health increases with aging has been supported by Rodin (1986).

A final explanation might be that despite the fact that couples are part of a broader social network and use external support in their daily lives, mutual support from the partner is the main factor related to their well-being. Satisfying intimate relationships have been found to be

particularly important for the well-being of the elderly (Lowenthal & Haven, 1968). In one of the few studies which described the everyday coping experiences of people, Pearlin et al. (1978) found that coping mechanisms in which the individual remains committed to and engaged only with relevant others were the most efficacious for psychological well-being. Similarly, McFarlane, Norman, Streiner and Roy (1983) stressed the importance of a small pool of intimates rather than a broad social network for well-being. Traupman et al. (1981) provided some evidence that the quality of intimacy may have a critical impact on the mental and physical health of older Americans by protecting them against depression and anxiety.

The theoretical perspectives still widely accepted today in social gerontology do not offer a framework for explaining findings of an absence of a relationship between the use of social support and well-being of the elderly. Activity theory (Neugarten, et al. 1968) and social network theory (Mitchell, 1969) stress the importance of being socially active and having wide networks of interpersonal relationships for well-being. However, exchange theory (Dowd, 1975) posits that it is the quality of interpersonal relationships that is the significant factor in understanding the well-being of the elderly. High levels of social activity and a broad social network may have little relationship to well-being.

A final issue concerns the F-Copes instrument itself. An important aspect of family coping not captured by the F-Copes instrument is that of the provision of social support by the elderly family. The F-Copes defines family coping only in terms of receiving support. In light of social exchange theories, interdependence or mutual interaction with the social network by means of acquiring as well as providing social support more realistically reflects coping of the elderly. In later life, giving support can be gratifying whereas being "overbenefited" can causes feelings of discomfort (Roberto & Scott, 1986).

Husband-Wife Patterns

In spite of the family nature of the coping instrument, there were differences between husbands and wives on their perception of use of selected family coping behaviours. The only items for which the correlation between husbands and wives was moderately high, were those that reflect major social values of the elderly such as "having faith in God" and "seeking professional counselling for difficulties". Moreover, congruency between husbands and wives on their perception of their use of internal family coping behaviours had an effect on the well-being of the wives only.

These findings raise the important question about the validity of a concept such as "Family Coping". Data from the present study suggest that families over time might not develop a shared perspective of the world. Partners might

use different reference points for their evaluation of family coping: family members coping collectively on an explicit shared problem, or family members coping with their own individual strategies for family problems as they perceive them. Olson and McCubbin (1983) in their descriptive study of family coping behaviours across the life cycle also found, using the same instrument, that family members had low levels of agreement on most family variables.

The Relationship between Conjugal Support, Family Coping Behaviours, and Well-being: A Proposed Model

The major concern of the present study was to explore the multiple relationships between the three key variables i.e. conjugal support, family coping behaviours and well-being and to understand the mechanism through which conjugal support works. Both conjugal support and family coping variables were hypothesized as contributing to the well-being of elderly marital partners. Conjugal support was hypothesized also as indirectly improving well-being through enhancing effective coping.

Contrary to the majority of studies on social support, coping and well-being, the proposed model (Figure 1) is one in which conjugal support and family coping were presumed to have a beneficial effect on well-being regardless of whether persons are in a particular crisis situation (main-

effect model). Extraneous variables including level of stress, functional ability, social network size, and socioeconomic status were added into the model for statistical control. The model was supported for selected dimensions of conjugal support, family coping and well-being over and above these control variables.

In the following section, the contribution of conjugal support and family coping to well-being will be addressed first followed by a discussion of the indirect effect of conjugal support on well-being through family coping.

The Contribution of Conjugal Support and Family Coping to Well-Being

In the final models (Figures 3 and 4), positive conjugal support was not a predictor of self-assessed health; however, it was a significant predictor of life satisfaction and marital satisfaction. This finding deserves comment because it is widely assumed that social support plays a role in physical as well as in mental health (Broadhead et al.,1983; Cassel, 1976; Cobb, 1976; Cohen, 1988; Cohen & Syme, 1985; Dean & Lin, 1977; House, Landis & Umberson, 1988).

Only a few studies have reported similar findings. Cwikel, Dielman, Kirscht and Israel (1988) as well as Billings et al. (1981) found a stronger association between social support and psychological well-being than between social support and health. Schaefer et al. (1981) found a

significant association between support and psychological symptoms and morale and a lack of a relationship between support and physical health.

One explanation for the non significant contribution of conjugal support to self-assessed health might be a methodological one. The Cantril ladder used to measure self-assessed health is a single-item measure with less variability than the Life Satisfaction Index and the visual analogue scale used to measure life satisfaction and marital satisfaction. Consequently the Cantril ladder might not be sensitive enough to discriminate health levels.

Nevertheless, another possible explanation is related to the conceptualization of the variables. In the present study, life satisfaction and marital satisfaction tapped the psychological dimensions of subjective well-being while health, measured by a self-anchoring scale, was defined by elderly marital partners as the ability to move around and to perform activities of daily living (Table 8). This definition of health is oriented toward autonomy and self-performance and does not incorporate the interpersonal dimensions implied in the concept of conjugal support. In a non-crisis situation or in ordinary life circumstances, life satisfaction and marital satisfaction might be more affected by the availability and reciprocity of conjugal support (positive conjugal support) than health, defined in terms of activity and mobility. Schaefer and colleagues

(1981), who found no relationship between social support and health, also conceptualized health by physical disability.

The contribution of positive conjugal support to life satisfaction and marital satisfaction suggests that intimate ties heighten psychological well-being by fulfilling basic social needs. There is evidence that intimacy contributes to the perceived well-being of individuals (Kessler & Essex, 1982; Traupman et al., 1981). Those who share ideas and feelings with someone who helps them deal with day-to-day problems are happier than those who do not (Cavan, 1973).

On the negative side of conjugal support, conflict was found to be a predictor of marital satisfaction of men only, that is high conflict scores were associated with low marital satisfaction of men. The ties of marriage offer benefits to men in excess of what they accord to women according to House et al. (1982). Consequently, men experiencing conflict might be more dissatisfied by their marital lives than women.

In the final models, the internal family coping behaviours, use of reframing and avoidance of passive appraisal, were related to selected well-being indicators. Reframing was related to all three indicators of well-being while avoidance of passive appraisal was related only to life satisfaction. More specifically, marital partners who used reframing as a coping strategy tended to rate their

health higher and to be more satisfied with their life and marriage than those who did not. Similarly, partners who avoided passive appraisal appeared to be more satisfied with their lives than those who employed strategies characterized by passivity and denial. Wheaton's (1985) finding of a main effect of mastery on health might be considered consistent with the finding of a direct positive effect of reframing on well-being. As discussed in the previous section, reframing is closely related to a sense of control or mastery. The selective contribution of passive appraisal to life satisfaction may be explained by those findings which demonstrate that people using passive coping strategies are more depressed than those who use active coping strategies (Billings et al. 1981). The differences in the contribution of conjugal support and family coping to the three well-being indicators underscore the importance of treating support, coping, and well-being as multidimensional constructs.

Husband-Wife Patterns

The literature on support, coping and well-being highlights small but consistent gender differences in the variance in well-being accounted for by support and coping. In Billings and Moos' study (1981), social support and coping together were found to account for more variance in functioning among women than among men; measures of coping and social support added roughly comparable increments to

the prediction of the criteria for women while the predictive value of social support was less salient among men. In contrast, in the present study, the models revealed small differences between men and women in the opposite direction. More variance in well-being of men was accounted for by conjugal support and internal family coping than in women.

These conflicting findings again might be explained by the different nature of the variables under study. In Billings and Moos's (1981) study, size of the social network rather than quality was considered and it has been shown that there are differences in the social networks of men and women, women having larger networks than men (Antonucci, 1985a; Corin, 1982). The fact that men generally maintain an intimate tie only with their spouse might explain why conjugal support, in the present study, is a more important factor in explaining well-being of men than women.

Finally, analyses of couple data emphasized the differences existing between the three well-being criteria. Reframing was found to have an effect on couples' self-assessed health and life satisfaction while positive conjugal support, as expected, was found to have an effect on couples' marital satisfaction.

The Indirect Effect of Conjugal Support on Well-Being through Family Coping

The finding that elderly marital partners perceiving high positive conjugal support use reframing, as a family coping strategy, and have positive perception of their health, life, and marital situation is particularly noteworthy. As the analyses demonstrated, the effect of positive conjugal support was primarily an indirect one, through the coping strategy of reframing. This indirect effect of positive conjugal support was consistent for the three measures of well-being.

Such a finding lends support to Lazarus' and Folkman's (1984) contention that perceived availability of support influences coping responses and that support may contribute to well-being through an intervening process i.e., through coping efforts (Ward, 1985). Mc Nett (1987) likewise found that the effect of perceived support on well-being was mediated through coping responses.

Cohen, Mermelstein, Kamarck and Hoberman (1985), Pearlin et al. (1981), and Thoits (1985) propose that support has esteem and mastery-enhancing properties which foster a sense of control. Theoretical discussions on coping and social support also refer to the beneficial effect of social support by way of its possible positive influence on the sense of control or mastery (Ben-Sira, 1984; Smith & Midanir, 1980). Cecirelli (1980) has demonstrated that the

quality of family relationships of older people is related to their sense of control. Therefore, positive conjugal support might have a beneficial effect on well-being through its positive effect on reframing (closely related to a sense of control) which in turn improves the well-being of the elderly.

Another but less important finding of the present study was that elderly marital partners perceiving less conflict in their conjugal relationship tended to avoid passive appraisal as a family coping strategy and, in turn, appeared to be more satisfied with their life. These results again emphasize the importance of considering, in addition to the positive aspects of support, the contribution of the costs or constraints of support on well-being. Analyses of both individual and couple data revealed that positive conjugal support had an effect on the couples' use of reframing and that conflict had an effect on the couples' use of passive appraisal.

In summary, a major finding of this study was that a supportive marriage is associated with the use of reframing which in turn is predictive of the well-being of both marital partners. While the proportions of the variance in well-being explained by conjugal support and family coping were not always large, these findings suggest that further efforts to clarify the role of specific types of support such as conjugal support in well-being are warranted.

Methodological Issues

One of the unique aspects of this study is that both individuals and couples were considered as the unit of analysis. To date, almost all of the research on families has relied primarily on data collected from one family member with the unit of analysis being that of the individual (Bokemeir & Monroe, 1983).

An important issue arising from such analyses relates to the different results obtained from aggregated and couple data. Aggregated data demonstrated no differences in the correlation coefficients of elderly men and women. Furthermore, the separate models of the relationship between conjugal support, family coping and well-being for men and women revealed fairly similar results. On the other hand, within-couple data, i.e. husband-wife data, showed considerable discrepancies between the perceptions of each marital partner.

These results suggest that what is true of family member scores at the aggregate level may not be true when considering family data. This phenomenon has been called the "ecological fallacy " or inversely the "individualistic fallacy" (Firebough, 1978).

Difference scores and correlational measures were used in the present study to reflect dyadic properties. In spite of the significant correlations between husbands and wives (within-couple) on certain study variables, such as conjugal

support, there were significant differences between husbands and wives' perceptions on these same variables. On the other hand, scores on variables such as self-assessed health and life satisfaction did not differ significantly within couples while their intraclass coefficients of correlation were only moderate. From a methodological point of view, these findings reflect that family members can differ on the average and yet still provide moderately correlated responses within family. Conversely, family members might not differ significantly but their scores may not follow strongly the same direction. This emphasizes the different properties of the usual methods used to assess couple data, i.e. correlational analyses and difference scores, and the importance of combining these methods in order to more fully describe and understand the experience of the couple as the unit of analysis.

In the present study, some variables such as reciprocity of conjugal support, family coping behaviours, and marital satisfaction were considered "family variables" or variables that captured some dimensions of the intra-dyadic relationship. Others, such as self-assessed health and life satisfaction, were viewed as "individual" variables. Results revealed discrepant perceptions between marital partners on family variables. Such perceptual discrepancies are not without precedent in the literature on marital interaction (Bernard, 1972). The existence of "his and her marriages"

is fairly well documented and raises important questions regarding the systemic quality of family life. As suggested by Safilios-Rothschild (1969), the possibility of "two realities", the husband's subjective reality and the wife's subjective reality, might explain these discrepancies, each partner perceiving facts differently according to his/her own needs, values, attitudes and beliefs.

However, such differences between husbands and wives were not revealed on individual variables such as self-assessed health and life satisfaction, reflecting in part the interdependence property of the family system, as proposed in the Family System Theory (Fawcett, 1975). The study findings underscore therefore the importance of considering both subjective perceptions of individual family members, and the family, as a unit.

Implications for Nursing Practice

The ultimate goal of this study was to identify the significant dimensions of conjugal support and family coping behaviours that account for the variation in the well-being of elderly couples. Results provide important insights into what might constitute a "healthy" elderly family environment, one which improves the quality of life.

The new philosophy of health care based on health promotion and the importance of returning to the family a feeling of competence and control (Epp, 1986), invites

nurses to participate in improving the quality of life of their clients through a collaborative approach. According to the McGill Model of Nursing (Gottlieb & Rowat, 1987), one feature of the nurse's role is that of assisting families to enhance or strengthen coping abilities and to utilize their own resources and potential for problem-solving in order to achieve a better quality of life. As nursing becomes more concerned with health care in the community, the role of social support and coping in quality of life assumes great practical significance for nursing.

Results of the present investigation suggest a number of possible nursing interventions. By assessing the strengths and deficiencies of the family system, nurses could, through anticipatory care and guidance, help the elderly couple acquire and maintain the family supports and coping strategies necessary for healthy survival. More specifically, nurses must "support the family support system".

Because the later years are often marked by a decline in the labor force and a decline in interaction with children (Stinnet, Collins & Montgomery, 1970), elderly marital partners, on a daily basis, are involved in a mutual exchange of helping behaviours. Therefore, assisting marital partners to develop the availability and reciprocity aspects of their relationship, possibly through an examination of their respective roles might be one means by which the nurse

can contribute to the quality of life of the elderly couple. Results of this study suggest that the "give and take" relationship is particularly important with this specific population. Diminishing health which often accompanies old age tends to increase dependence and to reduce the capacity to reciprocate support provided by others. This potential threat occurs at a time in the life cycle when satisfying intimate relationships are particularly important for well-being.

Findings from this study also point to the importance of the nurse considering not only the positive aspects but also the "darker side" of support in her clinical assessment of the elderly marital relationship. Interventions aimed at increasing the interpersonal skills of elderly marital partners are suggested by the present study.

Contrary to some of the literature which emphasizes the positive relationship between seeking support and well-being, only the internal or cognitive strategies were found to be related to the well-being of the elderly couple in the present study. Enhancing existing resources which reside in the couple or individuals is therefore suggested by this study. A role for nursing may be that of helping elderly couples learn techniques of cognitive restructuring, situational reinterpretation or reappraisal of the problems they experience in everyday living. Reframing, which is part of the problem solving process and comprises a range of

efforts directed at bringing about cognitive changes offers a fertile ground for assisting these couples. As stated by Rodin (1986), older persons can benefit from explicit training to develop skills for coping with daily stress. Assisting the elderly couple in assessing the coping strategies they use and in possibly learning new coping skills, such as reframing, is a means of enhancing feelings of mastery or control over daily problems. This may in turn positively affect well-being. A nursing approach such as this approach which emphasizes change and growth is congruent with a learning nursing model such as the McGill model of Nursing (Gottlieb & Rowat, 1987).

The present study findings also raise an important question: what does nursing the family mean? Despite the recent emphasis in nursing on considering the total family system rather than only individuals (Miller-Ham & Chamings, 1983), this study underscores the need to consider further the subjective perceptions of each family member. The findings which demonstrate discrepancies of perceptions between husbands and wives stress the point that by assessing the family through only one family member, the nurse might assess only part of family reality. Attention should be given to nursing the system of individuals as well as nursing the entire family system.

Finally, recent social changes would appear to indicate that as a nation we are now ready to recognize the impor-

tance of improving conditions for the elderly and providing health programs for them. This study underscores the importance of two psychosocial factors, i.e. conjugal support and family coping, shown to contribute to the well-being of the elderly couple. Nursing's role in assisting elderly couples with these dimensions of their lives appears clear. In so doing, the likelihood of continued community living for the elderly may be possible.

Recommendations for Future Research

One of the limitations of the study's cross-sectional design was the inability to establish the causal effects of the variables. Although conjugal support may affect cognitive family coping behaviours, cognitive family coping might also affect the appraisal of conjugal support. Similarly, it might be the perception of well-being that affects one's perception of conjugal support and perhaps the desirability of particular coping behaviours. A linear recursive model was proposed and despite the fact that statistical analyses controlled for non spuriousness of the relationships, one criterion of causality i.e time precedence was missing. A longitudinal design would capture the process of changes in conjugal support, family coping and well-being and make causal inferences more possible.

Results of this study are limited to self report data and may be affected by self-presentation bias. Although all

of the self report measures used in this study had been validated in prior research and qualitative data were collected on selected variables, future studies could be strengthened by triangulating on methods. Consideration of actual observed coping behaviours in naturalistic situations represents an area of great value for future research (Lewis, Woods, Hough & Bensley, 1990).

The use of a multistage sampling strategy and statistical control for extraneous variables, such as service utilization, were two strategies implemented to assure the representativeness of the sample of elderly couples. However, the hypothesized model of the relationship between conjugal support, family coping and well-being needs to be tested with middle aged and younger couples. Whether conjugal support has an indirect effect on well-being through family coping is a question that needs to be addressed with a younger population.

The conceptualizations and measurement of conjugal support and family coping behaviours used in this study were based on a variety of middle range theories (social exchange theory, family stress theory) compatible with the major framework directing this study, i.e. the McGill Model of Nursing (Gottlieb & Rowat, 1987). Nevertheless, there is an urgent need in nursing to develop instruments to measure dimensions of the family such as family coping, family support and family well-being, based on nursing frameworks.

More specifically, how best to measure family well-being remains a challenging question for nursing research.

Results of the present study also suggest that further investigation is needed in the area of family in order to determine the effects of similar or different perceptions of family members on the way a family actually functions and on family's well-being. Discrepant reports of partners on certain family variables raised theoretical and methodological questions about the concept of family system which also require further investigation. Finally, future research might include the assessment of the effectiveness of intervention strategies aimed at improving conjugal support and cognitive problem solving strategies with the ultimate goal of enhancing the quality of life of elderly couples.

CONCLUSION

The purpose of this study was to test the relationship between conjugal support, family coping behaviours in the face of everyday problems and the well-being of the elderly couple living in the community. A model linking the major variables was proposed. Results offer insights for further understanding the mechanisms by which these psychosocial variables affect well-being. Conjugal support was found to have a direct effect on well-being as well as an indirect effect through the use of internal family coping behaviours.

One important contribution of this thesis is the demonstration of a main-effect of conjugal support and cognitive coping strategies on well-being. Another contribution is that it considered three related dimensions of well-being thus permitting comparisons with previous studies on coping and support using global and more specific outcome measures. Indeed, results of this study emphasize the importance of carefully examining the conceptualization of the variables support, coping, and well-being used in studies before drawing conclusions.

This study is unique in providing a link between individual and family literature on support, coping and well-being. It also makes an important methodological contribution in considering both individual and couple data for analysis.

Finally, ensuring quality of life for the increasing numbers of elderly in society today is a challenge facing policy makers and those engaged in health care delivery. Findings from this study provide important insights into those factors which may contribute to the well-being of elderly couples living in the community, namely conjugal support and internal family coping behaviours. Such information provides directions for the development and implementation of strategies aimed at fostering the quality of life of this particular segment of the population.

REFERENCES

Adams, D. L. (1969). Analysis of a life satisfaction index. Journal of Gerontology, 24, 470-474.

Aitken, R. (1969). Measurement of feelings using visual analogue scale. Proceedings of the Royal Society of Medicine, 62, 989-993.

Amster, L. & Krauss, H. (1974). The relationship between life crises and mental deterioration in old age. International Journal of Aging and Human Development, 5, 51-55.

Andrews, F.M. & Withney, S.B. (1976). Social Indicators of Well-Being. New York: Plenum Press.

Andrews, G., Tennant, C., Hewson, D. & Vaillant, G.(1978). Life event stress, social support, coping style and risk of psychological impairment. The Journal of Nervous and Mental Disease, 166, 307-316.

Antonucci, T. (1985a). Personal characteristics, social support, and social behavior. In R. Binstock & E. Shanas (Eds). Handbook of Aging and the Social Sciences. New York: Van Nostrand Reinhold Cie.

Antonucci, T. (1985b). Social support: Theoretical advances recent findings and pressing issues. In I.G. Sarason & B.R. Sarason (Eds). Social Support: Theory, Research and Application (pp. 21-37). Boston: Martines Nijhoff Pub.

Antonucci, T. & Akiyama, H. (1987). An examination of sex differences in social support in mid and late life. Sex Roles, 17, 737-749.

Antonucci, T. & Depner, C. (1982). Social support and informal helping relationships. In T. Wills (Ed). Basic Processes in Helping Relationships (pp.233-254). New York: Academic Press.

Antonucci, T. & Israel, B. (1986). Veridicality of social support: A comparison of principal and network members' responses. Journal of Consulting and Clinical Psychology, 54, 432-437.

Atchley, R. (1982). The Process of Retirement: Comparing women and men. In M. Szinovacz (Ed). Women's Retirement Beverly Hills: Sage.

Baldassare, M., Rosenfield, S. & Rook, K. (1984). The types of social relations predicting elderly well-being. Research on Aging, 6, 549-559.

Ball, D., McKenry, P. & Price-Bonham, S. (1983). Use of repeated-measures designs in family research. Journal of Marriage and the Family, 45, 885-896.

Barer, B. & Johnson, C. (1990). A critique of the caregiving literature. The Gerontologist, 30, 26-29.

Baron, R. & Rodin, J. (1978). Perceived control and crowding stress. In A. Baum, J. Singer & S. Valin (Eds). Advances in Environmental Psychology (pp. 145-190) Hillsdale: Erlbaum.

Barusch, A. (1988). Problems and coping strategies of elderly spouse caregivers. The Gerontologist, 28, 677-685.

Benner, P., Roskies, E. & Lazarus, R.S. (1980). Stress and coping under extreme conditions. In J. E. Dimsdale (Ed). Surviviors Victims, and Perpetrators: Essays on the Nazi Holocaust (pp.219-259). Washington, DC: hemisphere.

Ben-Sira, Z. (1983). Loss, stress and readjustment: The structure of coping with bereavement and disability. Social Science and Medicine, 17, 1619-1632.

Ben-Sira, Z. (1984). Chronic illness, stress, and coping. Social Science and Medicine, 18, 725-736.

Berardo, F. M. (1980). Decade preview: Some trends and directions for family research and theory in the 1980s. Journal of Marriage and the Family, 42, 723-728.

Berger, P. L. & Luckmann, T. (1966). The Social Construction of Reality. New York: Doubleday.

Bergman, K., Foster, E., Justice, A. & Matthews, V. (1978). Management of the demented elderly patient in the community. British Journal of Psychiatry, 132, 441-449.

Berk, R. (1983) Applications of the general linear model to survey data. In P. Rossi, J. Wright and A. Anderson (Eds). Handbook of Survey Research (pp. 495-546).Orlando: Academic Press.

Berkman, L. (1986). Social networks, support and health: Taking the next step forward. American Journal of Epidemiology, 123, 559-562.

Berman, W. & Turk, D. (1981). Adaptation to divorce: Problems and coping strategies. Journal of Marriage and the Family, 43, 179-189.

Bernard, J. (1972). The Future of Marriage, New York: World Publishing.

Bigot, A. (1974). The relevance of American Life Satisfaction Indices for research on British subjects before and after retirement. Age and Aging, 3, 113-121.

Billings, A. G. & Moos, R. H. (1981). The role of coping responses on social resources in attenuating the stress of life events. Journal of Behavioral Medicine, 4, 139-157.

Billings, A.G. & Moos, R. H. (1984). Coping, stress and social resources among adults with unipolar depression. Journal of Personality and Social Psychology, 46, 877-891.

Black, M. (1985). Health and social support of older adults. Canadian Journal on Aging, 4, 213-226.

Blau, P. (1964). Exchange and Power in Social Life. New York: John Wiley.

Blau, Z. (1981). Aging in a Changing Society. New York: Franklin Watts.

Blazer, D. (1982). Social support and mortality in an elderly community population. American Journal of Epidemiology, 115, 684-694.

Blishen, B., Carroll, W. & Moore, C. (1987). The 1981 socioeconomic index for occupations in Canada. Canadian Review of Sociology and Anthropology, 24, 465-488.

Bokemeier, J. & Monroe, P. (1983). Continued reliance on one respondent in family decision-making studies: A content analysis. Journal of Marriage and the Family, 45, 467-480.

Bond, A. & Lader, M. (1974). The use of analogue scales in rating subjective feelings. British Journal of Medical Psychology, 47, 211-218.

Bradburn, N. (1969). The Structure of Psychological Well-Being. Chicago: Aldine.

Bradburn, N. (1983). Response effects. In P. Rossi, J. Wright & A. Anderson (Eds). Handbook of Survey Research (pp.289-328). Toronto: Academic Press.

Branch, L. & Jette, A. (1982). A prospective study of long-term care institutionalization among the aged. American Journal of Public Health, 72, 1373-1379.

Brinkerhoff, D. & White, L. (1978). Marital satisfaction in an economically marginal population. Journal of Marriage and the Family, 40, 825-835.

Broadhead, W., Kaplan, B., James, S., Wagner, E.,Schoenbach, V., Grimson, R., Heyden, S., Tibblin, G. & Gehlbach, S. (1983). The epidemiologic evidence for a relationship between social support and health. American Journal of Epidemiology, 117, 521-537.

Brock, A. (1985). A study to determine what variables predict institutionalization of elderly people. Journal of Advanced Nursing, 10, 533-537.

Brody, E. M. (1981). Women in the middle and family help to older people. Gerontologist, 21, 471-480.

Brody, S., Poulshock, W. & Mascioschi, C. (1978). Family care unit: A major consideration in the long-term support system. The Gerontologist, 18, 556-561.

Brown, G.M., Bhrolchain, M. & Harris, T. (1975). Social class and psychiatric disturbance among women in an urban population. Sociology, 9, 225-254.

Bruhn, J. & Philips, B. (1984). Measuring social support: A synthesis of current approaches. Journal of Behavioral Medicine, 7, 151-169.

Bureau de la Statistique du Québec (1986). Les Personnes Agées au Québec. Québec: Les Publications du Québec.

Burgess, R.L. & Huston, T. L. (1979). Social Exchange in Developing Relationships. New York: Academic Press.

Burke, R. J. & Weir, T. (1977). Husband-wife helping relationhips: The " mental hygiene" function in marriage. Psychological Reports, 40, 911-925.

Burke, R. J. & Weir,T. (1982). Husband-wife helping relationships as moderators of experienced stress: The "mental hygiene" function in marriage. In H. I. Mc Cubbin, A. E. Cauble J& M. Patterson (Eds). Family Stress, Coping, and Social Support (pp.221-238). New York: Charles C. Thomas.

Burr, W. (1970). Satisfaction with various aspects of marriage over the life cycle: A random middle class sample. Journal of Marriage and the Family, 32, 29-37.

Campbell, A., Converse, P. & Rogers, W. (1976). The Quality of American Life. New York: Russell Sage Foundation.

Campbell, T. (1986). Family's Impact on Health: A Critical Review and Annotated Bibliography. Washington: National Institute of Mental Health. Series DN no. 6.

Cantor, M. (1980). Caring for the Frail Elderly. Paper presented at the 33th Annual Scientific Meeting of the Gerontological Society. San Diego.

Cantril, H. (1965). The Pattern of Human Concerns. New Brunswick: Rutgers University Press.

Cassel, J. (1976). The contribution of the social environment to host resistance. American Journal of Epidemiology, 104, 107-123.

Cavan, R. (1973). Speculations on innovations to conventional marriage in old age. The Gerontologist, 13, 409-411.

Cecirelli, V. (1980). Relationship of family background variables to locus of control in the elderly. Journal of Gerontology, 35, 108-114.

Chappell, N. & Strain, L. (1985). Decision-Making among the Elderly and the Use of Health and Social Services. Interview Schedule. (pp.16-20). University of Manitoba: Centre on Aging.

Clark, M., & Anderson, B. (1967). Culture and Aging: An Anthropological Study of Older Americans. Springfield: Charles C. Thomas.

Clark, M., Levitt, M. & Finley, G. (1984). Perceived control, social support, and noninstitutional relocation of the elderly: An annotated bibliography. Psychological Documents, 14 (5) (Ms. No. 2619).

Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38, 300-314.

Cohen, F. & Lazarus, R. (1980). Coping with the stresses of illness. In G. Stone, F. Cohen & F. Adler (Eds). Health Psychology (pp. 217-254). San Francisco: Jossey Bass.

Cohen, J. (1977). Statistical Power Analysis for the Behavioral Sciences (rev. ed.).New York: Academic Press.

Cohen, S. (1988). Psychosocial models of the role of social support in the etiology of physical disease. Health Psychology, 7, 269-297.

Cohen, S. & Mc Kay,G. (1984). Social support, stress and the buffering hypothesis: A theoretical analysis. In A. Baum, J.E. Singer & S.E. Taylor (Eds.) Handbook of Psychology and Health, 4. Hillsdale: Earlbaum.

Cohen, S., Mermelstein, R., Kamarck, T. & Hoberman,H. (1985). Measuring the functional components of social support. In I. Sarason & B. Sarason (Eds). Social Support: Theory, Research and Application. The Hague: Martines Niijhoff.

Cohen, S. & Wills, T. A. (1985). Stress, social support and the buffering hypothesis. Psychological Bulletin, 98,310-357.

Cohler, B. & Lieberman, M. (1980). Social relations and mental health. Research on Aging, 2, 445-469.

Conner, K., Powers, E. & Bultena, G. (1979). Social interaction and life satisfaction: An empirical assessment of late-life patterns. Journal of Gerontology, 34, 116-121.

Corin, E. (1982). Les stratégies sociales d'existence des personnes âgées: Une analyse dynamique des réseaux sociaux. Santé Mentale au Canada, 30, 8-14.

Costa, P. T. & McCrae, R. R. (1983). Contribution of Personality research to an understanding of stress and aging. Marriage and Family Review, 6, 157-173.

Cwikel, J., Dielman, T., Kirscht, J. & Israel, B. (1988). Mechanisms of psychosocial effects on health: The role of social integration, coping style and health behavior. Health Education Quaterly, 15 151-173.

Dean, A. & Lin, N. (1977). The stress-buffering role of social support. Journal of Nervous Mental Disease, 169, 403-417.

Denzin, N. (1982). Contributions of anthropology and sociology to qualitative research methods. In E. Kuhns & S.W. Martorana (Eds). Qualitative Methods for Institutional Research (pp. 14- 21). San Francisco: Jossey Bass.

Depner, C. E. & Ingersoll-Dayton, B. (1983). Conjugal social support: Patterns in later life. Journal of Gerontology, 40, 761-766.

Depner, C. E. & Verbrugge, L. M. (1980). Social network and health behavior. In D. McGuigan (Ed). Women's Lives: New Theory, Research and Policy. Ann Arbor: University of Michigan.

Dillman, D. A. (1983). Mail and other self-administered questionnaires. In P. Rossi, J. wright & A. Anderson (Eds). Handbook of Survey Research (pp.359-377). Toronto: Academic Press.

Di Matteo, M. & Hays, R. (1981). Social support and serious illness. In B.H. Gottlieb (Ed).Social Networks and Social Support. Beverly Hills: Sage.

Donald, C. & Ware, J. (1984). The measurement of social support. Research in Community and Mental Health, 4, 325-370.

Dowd, J. J. (1975). Aging as exchange: A preface to theory. Journal of Gerontology, 30, 584-594.

Dressler, D. (1973). Life adjustment of retired couples. International Journal of Aging and Human Development, 4, 335-349.

Ducharme, F. (1984). Etude du Profil de Vie des Couples Ages à Domicile. Rapport de Recherche. Faculté des Sciences Infirmières: Université de Montréal.

Duff, R. & Hong, L. (1982). Quantity and quality of social interactions in the life satisfaction of older Americans. Sociology and Social Research, 66, 418-434.

Duke, M., Shaheen, J. & Nowicki, S. (1974). The determination of locus of control in a geriatric population and a subsequent test of the social learning interpersonal distances. Journal of Psychology, 86, 277-285.

Edwards, J. & Klemmack, D. (1973). Correlates of life satisfaction: A reexamination. Journal of Gerontology, 28, 497-502.

Elwell, F. & Maltbie-Crannell, A. (1981). The impact of role loss upon coping resources and life satisfaction of the elderly. Journal of Gerontology, 36, 223-232.

Epp, J. (1986). Achieving health for all: A framework for health promotion. Canadian Journal of Public Health, 77, 393-407.

Evans, G., Beland, D., Butler, J., Delongchamp, N., Kroetsch, K., Pearson, J. & Poling, A. (1975). Status passage passage characteristics and consequences for the aged: Comparison of preinstitutional and community elderly. Canadian Journal of Public Health, 66, 15-30.

Fawcett, J. (1975). The family as a living open system: An emerging conceptual framework for nursing. International Nursing Review, 22, 113-116.

Felton, B. & Kahana, E. (1974). Adjustment and situationally bound locus of control among institutionalized aged. Journal of Gerontology, 29, 295-301.

Felton, B. & Revenson, T.(1984). Coping with chronic illness: A study of illness controllability and the influence of coping strategies on psychological adjustment.Journal of Consulting and Clinical Psychology, 52, 343-353.

Felton, B., Revenson, T. & Hinrichsen, G. (1984). Stress and coping in the explanation of psychological adjustment among chronically ill adults. Social Science Medicine, 18, 889-898.

Ferguson, G. A. (1981). Statistical Analysis in Psychology and Education. Montreal: McGraw-Hill.

Ferrans, C. & Powers, M. (1985). Quality of life index: development and psychometric properties. Advances in Nursing Science, 8, 15-24.

Fiore, J., Becker, J. & Coppel, D. (1983). Social network interactions: A buffer or a stress. American Journal of Community Psychology, 11, 423-439.

Firebaugh, G. (1978). A rule for inferring individual level relationships from aggregate data. American Sociological Review, 43, 557-572.

Fisher, C. (1982). To Dwell among Friends. Chicago: University of Chicago Press.

Fisher, J., Nadler, A. & Alagna, S. (1982). Recipient reactions to aid. Psychological Bulletin, 91, 27-54.

Flanagan, J. C. (1982). Measurement of quality of life: Current state of the art. Archives of Physical Medical rehabilitation, 63, 56-59.

Foa, U. G. (1971). Interpersonal and economic resources. Science, 171, 345-351.

Folkman, S. & Lazarus, R. (1980). An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 21, 219-239.

Fuller, S. & Larson, S. (1980). Life events, emotional support, and health of older people. Research in Nursing and Health, 3, 81-89.

George, L. (1980). Role transitions in Later Life. Monterey, Calif:Brooks/Cole.

George, L. & Bearon, L. (1980). Quality of Life in Older Persons. Meaning and Measurement. New York: Human Science Press.

Glick, P. C. (1979). The future marital status and living arrangements of the elderly. The Gerontologist, 19, 301-309.

Gooding, B., Sloan, M. & Amsel, R. (1988). The well-being of older Canadians. The Canadian Journal of Nursing Research, 20, 5-18.

Gore, S. (1985). Social support and styles of coping with stress. In S. Cohen & S. Leonard (Eds). Social Support and Health. Montreal: Academic Press.

Gottlieb, L. & Rowat, K. (1987). The Mc Gill model of nursing: A practice-derived model. Advances in Nursing Science, 9, 51-61.

Gouvernement du Québec (1985). Un Nouvel Age à Partager. Politique du Ministère des Affaires Sociales à l'égard des personnes âgées. Québec: Ministère des Affaires Sociales du Québec.

Gove, W., Hughes, M. & Style, C. (1983). Does marriage have have a positive effects on the psychological well-being of the individual? Journal of Health and Social Behavior, 24, 122-131.

Government of Canada (1982). Canadian Governmental Report on Aging. Ottawa: Ministry of Services and Supply.

Gray, H., Brogan, D. & Kutner, N. (1985). Status of life-areas: Congruence/noncongruence in ESRD patient and spouse perceptions. Social Science and Medicine, 20, 341-346.

Greenberg, J. & Ginn, A. (1979). A multivariate analysis of the predictors of long-term care placement. Home Health Care Services Quarterly, 1, 75-99.

Greenberg, M. & Shapiro, S. (1971). Indebtedness: An adverse aspect of asking for and receiving help. Sociometry, 34, 290-301.

Gros, M. (1989). Nouvelle politique de santé mentale: espoirs et inquiétudes. Santé Société, 11, 21-22.

Gutman, G. (1980). The elderly at home and in retirement housing. A comparative study of health problems, functional difficulties and support service needs. In V . Marshall (Ed). Aging in Canada (pp. 189-200). Don Mills: Fitzhenry & Whiteside.

Harel, Z. & Deimling, G. (1984). Social resources and mental health: An empirical refinement. Journal of Gerontology, 39, 747-752.

Hatfield, E., Utne, M. & Traupman, J. (1979). Equity Theory and intimate relationships. In R. Burgess & T. Huston (Eds). Social Exchange in Developing Relationships(pp.99-133). New York: Academic Press.

Health and Welfare Canada (1988). Mental Health for Canadians: Striking a Balance. Ottawa: Minister of Supply and Services, Canada.

Hill, R. (1949). Families under Stress. Connecticut: Greenwood Press.

Holmes, C. (1989). Health care and the quality of life: a review. Journal of Advanced Nursing, 14, 833-839.

Holmes, T. & Masuda, M. (1974). Life change and illness susceptibility. In B. S. Dohrenwend & B. P. Dohrenwend (Eds). Stressful Life Events: Their Nature and Effects. New York: Academic Press.

Homans, G.C. (1974). Social Behavior: Its Elementary Forms (rev.ed.) New York: harcourt Brace Jovanovich.

Horowitz, A. (1979). Models, muddles and mental illness labeling. Journal of Health and Social Behavior, 20,296-300.

House, J. (1981). Work, Stress and Social Support. Menlo Park, CA: Addison-Wesley Publishing.

House, J., Landis, K. & Umberson, D. (1988). Social relationships and health. Science, 241, 540-545.

House, J., Robbins, C. & Metzner, H. (1982). The association of social relationships and activities with mortality: Prospective evidence from the Tecumseh community health study. American Journal of Epidemiology, 116, 123-140.

Hoyt, D., Kaiser, M., Peters, G. & Babchuk, N. (1980). Life satisfaction and activity theory: A multidimensional approach. Journal of gerontology, 35, 935-941.

Husaini, B., Newbrough, J., Neff, J. & Moore, M. (1982). The stress-buffering role of social support and personal competence among the rural married. Journal of Community Psychology, 10, 409-423.

Hymovich, D. & Dillon Baker, C. (1985). The needs, concerns, and coping of parents of children with cystic fibrosis Family Relations, 34, 91-97.

Ilfeld, F. (1982). Marital stressors, coping styles, and symptoms of depression. In L. Goldberger & S. Breznitz (Eds). Handbook of Stress: Theoretical and Clinical Aspects (pp.482-494). New York: The Free Press.

Information and Referral Centre of Greater Montreal Foundation (1988). Directory of Community Services of Greater Montreal. Welfare, Health, Recreation. Montreal.

Ingersoll, B. & Antonucci, T. (1983). Non-Reciprocal Social Support, Another Side of Intimate Relationships. Paper Presented at the Gerontological Society of America. San Francisco.

Ingersoll-Dayton, B. & Antonucci, T. (1988). Reciprocal and nonreciprocal social support: contrasting sides of intimate relationships. Journal of Gerontology, 43, 565-573.

Janis, I. & Rodin, J. (1985). Attribution, control, and decision making: Social psychology and health care. In C. Stone, F. Cohen & N. Adler(Eds) Health Psychology a Handbook (pp.487-521). Washington: Jossey-Bass.

Johnson, C. L.(1983). Dyadic family relations and social support. The Gerontologist, 23, 377-383.

Kahana, E., Kahana, B. & Young, R. (1987). Strategies of coping and postinstitutional outcomes. Research on Aging, 9, 182-199.

Kane, R. & Kane, R. (1981). Assessing the Elderly. Toronto: Lexington Books.

Kaplan, B., Cassel, J. & Gore, S. (1977). Social support and health. Medical Care, 15, 47-57.

Kaplan, R. & Ernst, J. (1983). Do category rating scales produce biased preference weights for a health index? Medical Care, 21, 193-207.

Kaplan, S. (1987). Patient reports of health status as predictors of physiologic health measures in chronic disease. Journal of Chronic Disease, 40, suppl. 1, 27S-35S.

Kasl, S. & Berkman, L. (1981). Psychosocial influences on health status of the elderly. The perspective of social epidemiology. In J. Mc Gaugh & S. Kiesler (Eds). Aging: Biology and Behavior (pp. 345-385). New York: Academic Press.

Katz, S. (1987). The science of quality of life. Journal of Chronic Disease, 40, 459-471.

Kelsey, J. L., Thompson, W. D. & Evans, A. S. (1986). Methods in Observational Epidemiology. New York: Oxford University Press.

Kerlinger, F. (1986). Foundations of Behavioral Research. New York: Holt, Rinehart and Winston.

Kessler, R. & Essex, M. (1982). Marital status and depression: The importance of coping resources. Social Forces, 61, 484-507.

Kessler, R., Mc Leod, J. & Wethington, E. (1985). The costs of caring: A perspective on the relationship between sex and psychological distress. In I. Sarason & B. Sarason (Eds). Social Support: Theory, Research and Application(pp. 491-506). Boston: Martinus Nyhoff Pub.

Kessler, R., Price, R. & Wortman, C. (1985). Social factors in psychopathology. Annual Review of Psychology, 36, 531-572.

Khan, R. (1979). Aging and social support. In M. Riley (Ed). Aging from Birth to Death. Boulder, CO: Westview Press.

Khan, R. & Antonucci, T. (1984). Social Supports of the elderly:Family/Friends/Professionals. Final report to the National Institute on Aging. Bethesda, MD.

Kilpatrick, F. & Cantril, H. (1960). Self-anchoring scaling: a measure of individuals' unique reality worlds. Journal of Individual Psychology, 16, 158-173.

Kobasa, S., Maddi, S. & Courington, S. (1981). Personality and constitution as mediators in the stress-illness relationship. Journal of health and Social Behavior, 22, 368- 378.

Kobasa, S., Maddi, S. & Kahn, S. (1982). Hardiness and health: A prospective study. Journal of Personality and Social Psychology, 42, 168-177.

Kobrin, F. E. (1981). Family extension and the elderly: Economic, demographic and family cycle factors. Journal of Gerontology, 36, 370-377.

Kohen, J. A. (1983). Old but not alone: Informal social supports among the elderly by marital status and sex. The Gerontologist, 23, 57-63.

Kraus, A., Spasoff, R., Beattie, E., Holden, E., Lawson, J., Rodenburg, M. & Woodcock, G. (1976). Elderly a p - plicants to long-term care institutions I. Their characteristics, health problems and state of mind. Journal of the American Geriatric Society, 24, 165-172.

Krause, N. (1986). Stress and coping: Reconceptualizing the role of locus of control beliefs. Journal of Gerontology, 41, 617-622.

Krause, N. (1987). Satisfaction with social support and self-rated health in older adults. The Gerontologist, 27, 301-308.

LaRocco, J., House, J. & French, J. (1980). Social support, occupational stress and health. Journal of Health and Social Behavior, 21, 202-218.

Larson, R. (1978). Thirty years of research on the subjective well-being of older Americans. Journal of Gerontology, 33, 109-125.

Laschinger, S. (1984). The relationship of social support to health in elderly people. Western Journal of Nursing Research, 6, 341-350.

Lavee, Y., McCubbin, H. & Patterson, J. (1985). The Double ABCX Model of Stress and Adaptation: An empirical test by analysis of structural equations with latent variables. Journal of Marriage and the Family, 47, 811-825.

Lawton, P. (1972). The dimensions of morale. In D. Kent, R.Kastenbaum & S. Sherwood (Eds). Research, Planning and Action for the Elderly. New York: Behavioral Publications.

Lazarus, R. (1981). The stress and coping paradigm. In C. Eisdorfer, D. Cohen, A. Kleinman & P. Maxim (Eds). Models for Clinical Psychopathology (pp. 117-214), New York: Spectrum.

Lazarus, R. & DeLongis, A. (1983). Psychological stress and coping in aging. American Psychologist, 38, 245-254.

Lazarus, R. & Folkman, S. (1984). Stress, Appraisal and Coping New York: Springer.

Lee, G. R. (1985). Kinship and social support: The case of the United States. Aging and Society, 5, 19-38.

Leventhal, G., Allen, J & Kemelgor, B. (1969). Reducing inequity by reallocating rewards. Psychonomic Sciences, 14, 295-296.

Levitt, M., Clark, M., Rotton, J. & Finley, G. (1987). Social support, perceived control, and well-being: A study of an environmentally stressed population. International Journal of Aging and Human Development, 25, 247-258.

Lewis, F., Woods, N., Hough, E. & Bensley, L. (1990). The family's functioning with chronic illness in the mother: the spouse's perspective. Social Science and Medicine, 29, 1261-1269.

Liang, J., Dvorkin, L., Kahana, E. & Mazian, F. (1980). Social integration and morale: A re-examination. Journal of Gerontology, 35, 746-757.

Llewellyn-Thomas, H., Sutherland, H., Ciampi, A., Etezadi-Amoli,J., Boyd, N. & Till, J. (1984). The assessment of values in laryngeal cancer: reliability of measurement methods. Journal of Chronic Diseases, 37, 283-291.

Lohmann, N. (1977). Correlations of life satisfaction, morale, and adjustment measures. Journal of Gerontology, 32, 73-75.

Lowenthal, M. & Haven, C. (1968). Interaction and adaptation: Intimacy as a critical variable. American Sociological Review, 33, 20-30.

Lowenthal, M., Thurnher, M. & Chiriboga, D. (1975). Four Stages of Life. San Francisco: Jossey Bass.

Mancini, J. (1979). Family relationships and morale among people 65 years of age and older. American Journal of Orthopsychiatry, 49, 292-300.

Mancini, J., Quinn, W., Gavigan, M. & Franklin, H. (1980). Social network interaction among older adults: Implications for life satisfaction. Human Relations, 33, 543-554.

Martin, C. & Anctil, H. (1989). La promotion de la santé: une perspective, une pratique. Santé Société. Collection promotion de la santé.

McAuley, W. & Prohaska, T. (1982). Professional recommendations for long-term care placement: A comparison of two groups of institutionallyvulnerable elderly. Home Health Care Services Quarterly, 2, 44-57.

McCrae, R. (1982). Age differences in the use of coping mechanisms. Journal of Gerontology, 37, 454-460.

McCrae, R. & Costa, P. (1986). Personality, coping and coping effectiveness in an adult sample. Journal of Personality, 38, 385-405.

McCubbin, H., Dahl, B. & Hunter, E. (1976). Research on the military family: A review. In H. Mc Cubbin, B. Dahl & E.Hunter (Eds) Families in the Military System. Beverly Hills:Sage.

McCubbin, H., Dahl, B., Lester, G., Benson, D. & Robertson, M.(1976). Coping repertoires of families adapting to prolonged war-induced separations. Journal of Marriage and the Family, 38, 461-471.

McCubbin, H., Joy, C., Cauble, A., Comeau, J., Patterson, J. & Needle, R. (1980). Family, stress and coping: A decade review. Journal of Marriage and the Family, 855-871.

McCubbin, H., Nevin, R., Cauble, A., Larsen, A. Comeau, J. & Patterson, J. (1982). Family coping with chronic illness: The case of cerebral palsy. In H. McCubbin, A. Cauble, & JPatterson (Eds) Family Stress, Coping and Social Support. Sprinfield, Illinois: Charles C. Thomas Publishers.

McCubbin, H., Olson, D. & Larsen, A. (1987). F-Copes- Family Crisis oriented personal evaluation scales. In H. McCubbin & A. Thompson (Eds). Family Assessment Inventories for Research and Practice (pp.195-207). Madison: University of Wisconsin.

McCubbin, H. & Patterson, J. (1983). The family stress process: The double ABCX model of adjustment and adaptation. Marriage and Family Review, 6, 7-37.

McCubbin, H. & Thompson, A. (1987). Family Assessment Inventories for Research and Practice. Madison: University of Wisconsin-Madison.

McCullough, L. (1984). Philosophical and ethical dimensions of the quality of life. Quality of Life and Cardiovascular Care, October, 18-22.

McFarlane, A., Neale, K., Norman, G., Roy, R. & Streiner, D. (1981). Methodological issues in developing a scale to measure social support. Schizophrenia Bulletin, 7, 90-100.

McFarlane, A., Norman, G., Streiner, D. & Roy, R. (1983). The process of social stress: Stable, reciprocal and mediating relationships. Journal of Health and Social Behaviors, 24, 160-173.

McNett, S. C. (1987). Social support, threat, and coping responses and effectiveness in the functionally disabled. Nursing Research, 36, 98-103.

Menaghan, E. G. (1982). Measuring coping effectiveness: A panel analysis of marital problems and coping efforts. Journal of Health and Social Behavior, 23, 220-234.

Menaghan, E. G. (1983a). Coping with parental problems: Panel assessment of effectiveness. Journal of Social Issues, 4.

Menaghan, E. G. (1983b). Individual coping efforts and family studies: Conceptual and Methodological Issues. Marriage and Family Review, 6, 113-135.

Mercer, R. & Ferketich, S. (1988). Stress and social support as predictors of anxiety and depression during pregnancy. Advances in Nursing Science, 10, 26-39.

Messick, D. M. & Cook, K. S. (1983). Equity Theory. New York: Praeger.

Miller, J. F. (1983). Coping with chronic illness. In J.F. Miller. Coping with Chronic Illness (pp.15-36). Philadelphia: Davis.

Miller-Ham, L. & Chamings, P. (1983). Family nursing: historical perspectives. In I. Clements & F. Roberts (Eds). Family Health: A Theoretical Approach to Nursing Care. New York: John Wiley.

Minkler, M. (1985). Social support and health of the elderly. In S. Cohen & L. Syme (Eds). Social Support and Health, (pp. 199-216). Montreal: Academic Press.

Minkler, M, Satariano, W. & Langhauser, C. (1983). Supportive exchange: An exploration of the relationship between social contacts and perceived health status in the elderly. Archives of Gerontology and Geriatrics, 2, 211-220.

Mitchell, J. (1969). The concept and use of social networks In J. C. Mitchell (Ed) Social Networks in Urban Situation. (pp. 1-50). Manchester: manchester University Press.

Moos, R. (1977). Coping with Physical Illness. New York: Plenum.

Mor, V., Wachtel, T. & Kidder, D. (1985). Patient predictors of hospice choice. Hospital versus home care programs. Medical Care, 23, 1115-1119.

Morganti, J., Nehrke, M., Hulicka, I. & Cataldo, J. (1988). Life-span differences in life satisfaction, self-concept, and locus of control. International Journal of Aging and Human Development, 26, 45-56.

Mossey, J. & Shapiro, E. (1982). Self-rated health: A predictor of mortality among the elderly. American Journal of Public Health, 72, 800-808.

Mueller, D., Edwards, D. & Yarves, R. (1977). Stressful life events and psychiatric symptomatology: Change or undesirability? Journal of Health and Social Behavior, 18, 307-317.

National Advisory Council on Aging (1986) Priorities for Action. A report of the National Advisory Council on Aging. Ottawa: Minister of Supply and Services, Canada.

National Advisory Council on Aging (1989). Understanding Seniors' Independence. Summary report. Ottawa: Minister of Supply and Services, Canada.

Neugarten, B., Havighurst, R. & Tobin, S. (1961). Measurement of life satisfaction. Journal of Gerontology, 16, 134-143.

Neugarten, B., Havighurst, R. & Tobin, S. (1968). Personality and patterns of aging. In B. Neugarten (Ed). Middle Age and Aging. Chicago: University of Chicago Press.

Noh, S. & Turner, R. (1987). Living with psychiatric patients:Implications for the mental health of family members. Social Science and Medicine. 25, 263-271.

Nuckolls, K., Cassel, J. & Kaplan, B. (1972). Psychosocial assets, life crisis, and the prognosis of pregnancy. American Journal of Epidemiology, 95, 431-441.

Olson, D. & Mc Cubbin, H. (1983). Families-What Makes them Work. Beverly-Hills: Sage.

Palmore, E. (1976). Total chance of institutionalization among the aged. The Gerontologist, 16, 504-507.

Palmore, E. & Luikart, C. (1972). Health and social factors related to life satisfaction. Journal of Health and Social Behavior, 13, 68-80.

Parmelee, P. A. (1983). Spouse versus other family caregivers: Psychological impact on impaired aged. American Journal of Community Psychology, 11, 337-349.

Pearlin, L., Lieberman, M., Menaghan, E. & Mullen, J.(1981). The stress process. Journal of Health and Social Behavior, 22, 337-356.

Pearlin, L. & Schooler, C. (1978). The structure of coping. Journal of Health and Social Behavior, 19, 2-21.

Pedhazur, E. (1982). Multiple Regression in Behavioral Research. New York: Holt, Rinehart & Winston.

Powers. B. A. (1988). Social networks, social support, and elderly institutionalized people. Advances in Nursing Science, 10, 40-57.

Pratt, C., Schmall, V., Wright, S. & Cleland, M. (1985). Burden and coping strategies of caregivers to Alzheimer's patients. Family Relations, 34, 27-33.

Pratt, L. (1972). Conjugal organization and health. Journal of Marriage and the Family, 34, 85-95.

Priest, G. (1988). Living arrangements of Canada's "older elderly" population. Canada Social Trends, autumn, 26-30.

Priestman, T. & Baum, M. (1976). Evaluation of quality of life in patients receiving treatment for advanced breast cancer. The Lancet, 24, 899-900.

Procidano, M. & Heller, K. (1983). Measures of perceived social support from friends and from family: Three validation studies. American Journal of Community Psychology, 11, 1-25.

Quayhagen, M. & Quayhagen, M. (1988). Coping with conflict. Research on Aging, 4, 364-375.

Rands, M. & Levinger, G. (1979). Implicit theories of relationship: An intergenerational study. Journal of Personality and Social Psychology, 37, 64.

Reiss, D. (1981). The Family's Construction of Reality. Cambridge, MA: Harvard University Press.

Reiss, D. & Oliveri, M. (1980). Family paradigm and family coping: A proposal for linking the family's intrinsic adaptive capacities to its responses to stress. Family Relations, 29, 431-444.

Rettig, K. & Bubolz, M. (1983). Interpersonal resource exchange as indicators of quality of marriage. Journal of Marriage and the Family, 45, 497-509.

Riley, D. & Eckenrode, J. (1986). Subgroup differences in costs and benefits. Journal of Personality and Social Psychology, 51, 770-778.

Roberto, K. & Scott, J. (1986). Equity considerations in the friendships of older adults. Journal of Gerontology 41, 241-247.

Robinson, K. (1989). Predictors of depression among wife caregivers. Nursing Research, 38, 359-362.

Rock, D., Green, K., Wise, B. & Rock, D. (1984). Social support and social network scales: A psychometric review. Research in Nursing and Health, 7, 325-332.

Rodin, J. (1986). Aging and health: Effects of the sense of control. Science, 233, 1271-1276.

Rollins, B. & Cannon, K. (1974). Marital satisfaction over the life cycle: A reevaluation. Journal of Marriage and the Family, 36, 271-283.

Rook, K. S. (1984). The negative side of social interaction: Impact on psychological well-being. Journal of Personality and Social Psychology, 46, 1097-1108.

Rook, K. S. (1987). Reciprocity of social exchange and social satisfaction among older women. Journal of Personality and Social Psychology, 52, 145-154.

Rossi, P., Wright, J. & Anderson, A. (Eds). Handbook of Survey Research. New York: Academic Press.

Rothman, K. J. (1986). Modern Epidemiology. Boston: Little Brown.

Safilios-Rothschild, C. (1969). Family sociology or wives' family sociology: A cross cultural examination of decision-making. Journal of the Marriage and the Family, 31, 290-301.

Sarason, I., Johnson, J. & Siegel, J. (1978). Assessing the impact of life changes: Development of the life experiences survey. Journal of Consulting and Clinical Psychology, 46, 932-946.

SAS Institute Inc. (1987). Changes and Enhancements to Base SAS Software for Personal Computers, Release 6.03. Cary, NC: SAS Institute Inc.

Scanzoni, J. (1979). Social exchange and behavioral independence. In R. L. Burgess & T. L. Huston (Eds). Social Exchange in Developing Relationships. New York: Academic Press.

Schaefer, C., Coyne, J. & Lazarus, R. (1981). The health-related functions of social support. Journal of Behavioral Medicine, 4, 381-405.

Schreiber, M. & Hughes, S. (1982). The Chicago five hospital home-bound elderly program: A long-term home care model. Pride Institution Journal of Home Health Care, 1, 12-20.

Schulz, R. (1980). Aging and control. In J. Garber & M. Seligman (Eds). Human Helplessness. Theory and Applications. New York: Academic Press.

Schumm, W., Barnes, H., Bollman, S., Jurich, A. & Milliken, G. (1985). Approaches to the statistical analysis of family data. Home Economics Research Journal, 14, 112-122.

Schwenger, C. & Gross, H. (1987). Institutional care and institutionalization of the elderly in Canada. In V. Marshall (Ed). Aging in Canada. Social Perspectives. Don Mills: Fitzhenry & Whiteside.

Shanas, E. (1979). The family as a social support system in old age. The Gerontologist, 19, 169-174.

Shanas, E., Townsend, P., Wedderburn, H., Milhoj, P. & Stehouwer, J. (1968). Old People in Three Industrial Societies. New York: Artherton Press.

Shulman, N. (1976). Network analysis: A new addition to an old bag of tricks. Acta Sociologica, 19, 307-323.

Shumaker, S. & Jackson, J. (1979). The aversive effects of nonreciprocated benefits. Social Psychology Quarterly, 42, 148-158.

Sicotte, C. (1982). Evaluation des Bénéficiaires en Centre d'Accueil d'Hébergement et en Centres Hospitaliers de Soins Prolongés. Québec: Ministère des Affaires Sociales.

Siegler, I. & George, L. (1983). The normal psychology of the aging male: Sex differences in coping and perceptions of life events. Journal of Psychiatry, 16, 197-209.

Simons, R. & West, G. (1985). Life changes, coping resources and health among the elderly. International Journal of Aging and Human Development, 20, 173-290.

Smith, R. & Midanir, L. (1980). The effects of social resources on recovery and perceived sense of control among the disabled. Sociology of Health and Illness, 2, 48-63.

Smyer, M. (1980). The differential usage of services by impaired elderly. Journal of Gerontology, 35, 249-255.

Spakes, P. (1979). Family, friendship and community interaction as related to life satisfaction of the elderly. Journal of Gerontological Social Work, 1, 279-294.

Spanier, G. & Lewis, R. (1980). Marital quality: A review of the seventies. Journal of Marriage and the Family, 42, 825-839.

Spanier, G., Lewis, R. & Cole, C. (1975). Marital adjustment over the family life cycle: The issue of curvilenearity. Journal of Marriage and the Family, 37, 263-275.

Spark, G. & Brody, E. (1970). The aged as family members. Family Process, 9, 195-210.

Spitzer, W. (1987). State of science 1986: Quality of life and functional status as target variables for research. Journal of Chronic Disease, 40, 465-471.

Statistics Canada (1986). The Seniors Boom. Ottawa: Minister of Supply and Services.

Statistics Canada (1987). Health and Social Support, 1985. Ottawa: Minister of Supply and Services.

Statistics Canada (1988). Recensement Canada 1986. Ottawa.

Stinnet, N., Collins, J. & Montgomery, J. (1970). Marital need satisfaction of older husbands and wives. Journal of Marriage and the family, 32, 428-434.

Stokes, S. & Gordon, S. (1988). Development of an instrument to measure stress in the older adult. Nursing Research, 37, 16-19.

Stoller, E. P. (1984). Self-assessments of health by the elderly: The impact of informal assistance. Journal of Health and Social Behavior, 25, 260-270.

Stoller, E. P. & Earl, L. L. (1983). Help with activities of everyday life: Sources of support for the noninstitutionalized elderly. The Gerontologist, 23, 64-70.

Stolzenberg, R. & Land, K. (1983). Causal modeling and survey research. In P. Rossi, J. Wright & A. Anderson (Eds). Handbook of Survey Research (pp.613-675). Orlando: Academic Press.

Strain, L. & Chappell, N. (1982). Confidants, do they make a difference in quality of life? Research on Aging, 4, 479-502.

Sussman, M. & Steinmetz, S. (Eds) (1987). Handbook of Marriage and the Family. New York: Plenum Press.

Sutherland, H., Dunn, V. & Boyd, N. (1983). Measurement of values for states of health with linear analogue scales. Medical Decision Making, 3, 477-487.

Swanson, D. & Maruta, T. (1980). The family's viewpoint of chronic pain. Pain, 8, 163-166.

Tardy, C. (1985). Social suport measurement. American Journal of Community Psychology, 13, 187-202.

Thoits, P. (1982). Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. Journal of Health and Behavior, 23, 145-159.

Thoits, P. (1985). Social support and psychological well-being: Theoretical possibilities. In I. Sarason & B. Sarason (Eds). Social Support: Theory, Research and Application (pp.51-72). The Hague: Maartinus Nijhof.

Thompson, L. & Walker, A. (1982). The dyad as the unit of analysis: Conceptual and methodological issues. Journal of Marriage and the Family, 44, 889-900.

Tilden, V. (1985). Issues of conceptualization and measurement of social support in the construction of nursing theory. Research in Nursing and Health, 8, 199-206.

Tilden, V. (1987). Interpersonal Relationships Inventory. Oregon Health Sciences University, School of Nursing.

Tilden, V. & Galyen, R. (1987). Cost and conflict. The darker side of social support. Western Journal of Nursing Research, 9, 9-18.

Tilquin, C., Sicotte, C., Paquin, T., Tousignant, F., Gagnon, G. & Lambert, P. (1980). The physical,emotional and social condition of an aged population in Quebec. In V. Marshall (Ed). Aging in Canada. (pp.222-231). Don Mills: Fitzhenry & Whiteside.

Townsend, P. (1965). The effects of family structure on the likelihood of admission to an institution in old age: The application of a general theory. In E. Shanas & F. Streib (Eds). Social Structure and the Family (pp.163-167). Englewood Cliffs: Prentice Hall.

Traupmann, J. & Hatfield, E. (1981). Love and its effect n mental and physical health. In E. Fogel, E. Hatfield, S. Kiesler & E. Shanas (Eds). Aging: Stability and Change in the Family. New York: Academic Press.

Traupmann, J., Hatfield, E. & Sprecher, S. (1981). The Importance of "Fairness" for the Marital Satisfaction of Older Women. Unpublished Manuscript. University of Wisconsin-Madison.

Troll, L. (1971). The family of later life: A decade review. Journal of Marriage and the Family, 33, 263-290.

Turk, D. C. (1979). Factors influencing the adaptive process with chronic illness. In I.G. Sarason & C.D. Spielberger (Eds) Stress and Anxiety (vol.6) (pp. 291-312). Washington: Halsted Press Book.

Turner, R. (1981). Social support as a contingency in psychological well-being. Journal of Health and Social Behavior, 22, 357-367.

Turner, R., Frankel, B. & Levin, D. (1983). Social support: Conceptualization, measurement and implications for mental health. Research in Community and Mental Health, 3, 67-111.

Unger, D. G. & Powell, D. R. (1980). Supporting families under stress: The role of social networks. Family Relations, 29, 566-574.

Verbrugge, L. (1979). Marital status and health. Journal of Marriage and the Family, 5, 267-285.

Veroff, J., Douvan, E. & Kulka, R. (1981). The Inner American. New York: Basic Books.

Walster, E., Berscheid, E. & Walster, W. (1973). New directions in equity research. Journal of Personality and Social Psychology, 25, 151-176.

Wan, T. & Weissert, W. (1981). Social support networks, patient status and institutionalization. Research on Aging, 3, 240-256.

Ward, R. A. (1985). Informal networks and well-being in later life: A research agenda. The Gerontologist, 25, 55-61.

Ward, R., LaGory, M. & Sherman, S. (1982). The relative importance of social ties. Gerontologist, 22, (Special Issue), 123.

Ward, R., Sherman, S. & LaGory, M. (1984). Informal networks and knowledge of services for older persons. Journal of Gerontology, 39, 216-223.

Warner, S. C. & Williams, J. I. (1987). The meaning in life scale: Determining the reliability and validity of a measure. Journal of Chronic Disease, 40, 503-512.

Weissert, W. & Scanton, W. (1985). Determinants of nursing home discharge status. Medical Care, 23, 333.

Wellman, B. (1981). Applying network analysis to the study of support. In B.H. Gottlieb (Ed). Social Networks and Social Support (pp.171-200). Beverly Hills: Sage.

Wentkowski, G. J. (1981). Reciprocity and the coping strategies ofolder people: Cultural dimensions of network building. The Gerontologist, 21, 600-609.

West, G. & Simons, R. (1983). Sex differences in stress, coping resources, and illness among the elderly. Research on Aging, 5, 253-268.

Wethington, E. & Kessler, R. (1986). Perceived support, received support and adjustment to stressful life events. Journal of Health and Social Behavior, 27, 78-89.

Wheaton, B. (1983). Stress, personal coping resources and psychiatric symptoms: An investigation of interactive models. Journal of Health and Social Behavior, 24, 208-229.

Wheaton, B. (1985). Personal resources and mental health: can there be too much of a good thing. Research in Community and Mental Health, 5, 139-184.

Williams, A., Ward, J. & Donald, C. (1981). A model of mental health, life events and social supports applicable to general populations. Journal of Health and Social Behavior 22, 324-336.

Wood, V., Wylie, M. & Schafer, B. (1969). An analysis of a short self-report measure of life satisfaction: Correlation with rater judgment. Journal of Gerontology, 24, 324-326.

Word Perfect Corporation (1988). Word Perfect. Version 5.0.

York, J. & Calsyn, R. (1977). Family involvement in nursing homes. Gerontologist, 17, 500-505.

Zealley, A. & Aitken, R. (1969). Measurement of mood. Proceedings of the Royal Society of Medicine, 62, 993-996.

Zimmer, J. (1975). Characteristics of patients and care provided in health-related and skilled nursing facilities. Medical Care, 13, 992-1010.

APPENDIX A

Information to Nurses or Directors Making First Contact

(English and French Versions)

ENGLISH VERSION

Dear Sir, Madam,

The purpose of this letter is to solicit your support in my research project on elderly couples living at home. I would, as investigator, require your assistance in selecting elderly couples as well as establishing the first contact with them.

My goal in this study is to explore how elderly couples manage at home and to discover some factors which favour the well-being of these couples living in the community. Your assistance in preparing a list of couples known to you, the spouses being of at least 65 years of age and able to answer a verbal questionnaire, would be greatly appreciated. Secondly and when you next met or call these couples, I would appreciate if you could mention the following to them:

a) That a nurse, interested in the well-being of people 65 and over living within the community, has undertaken a study on the day-to-day situation of couples of this age group

b) That if they accept to give her their names, this nurse would be interested in discussing her project with them

c) That if they accept, this nurse will communicate with them by phone in order to more fully explain her project and to give them the opportunity to decide if they would be interested in participating in this study

I will be communicating with you in the next few days in order to obtain a list of consenting couples. I take this opportunity to sincerely thank you for your precious time and cooperation on this aspect of my research project.

If additional information is required, please call me at the following number:

Please accept my best regards

Francine Ducharme, RN, M.Sc.
Ph.D. Student,
Mc Gill University

FRENCH VERSION

Chers Monsieur, Madame,

La présente est pour solliciter votre collaboration en vue de la réalisation d'un projet de recherche sur le vécu des couples âgés habitant à domicile. En tant qu'investigatrice de ce projet, j'aurais besoin de votre aide pour la sélection des couples âgés de même que pour établir le premier contact avec ceux-ci.

Le but de mon étude est d'explorer la façon dont transigent les couples âgés avec leurs difficultés quotidiennes à domicile afin de découvrir des facteurs favorisant le bien-être de cette clientèle. Afin de réaliser ce projet, je vous serais grandement reconnaissante si vous pouviez dresser la liste des couples que vous connaissez dont les deux conjoints sont âgés de 65 ans et plus et sont capables de répondre à des questionnaires oraux. Les questions portent, entre autres, sur la santé, la satisfaction de vivre, la façon dont les sujets résolvent leurs problèmes quotidiens et le soutien qu'ils reçoivent de leur conjoint et de l'environnement.

J'apprécierais, dans un deuxième temps, que vous informiez ces couples de mon projet en leur mentionnant les précisions suivantes:

a) Qu'une infirmière intéressée à la qualité de vie des personnes de plus de 65 ans fait actuellement une recherche sur le vécu des couples habitant à domicile

b) Que cette infirmière serait intéressée à leur parler de son projet s'ils acceptent que leurs noms lui soient transmis.

c) Que cette infirmière communiquera avec eux par téléphone et expliquera davantage son projet afin qu'ils puissent prendre leur decision d'y participer ou non.

Enfin, je vous serais reconnaissante si vous pouviez communiquer avec moi lorsque vous aurez en votre possession les coordonnés des couples acceptant que je leur téléphone. Je vous remercie sincèrement de votre précieuse collaboration sans laquelle ce projet ne pourrait être mené à bien.

Veuillez agréer, Monsieur, Madame, l'expression de mes sentiments les meilleurs.

Francine Ducharme, Inf., M.Sc.
Candidate au Doctorat, U. McGill(461-1967)

APPENDIX B

Modified Version of the Interpersonal Relationship Inventory Assessing Conjugal Support (English and French Versions)

Permission to Modify the IPRI

MODIFIED VERSION OF THE IPRI
ASSESSING CONJUGAL SUPPORT

Most relationships with a spouse are both helpful and stressful. I will read you various statements that describe some characteristics of spousal relationships. Please listen to each statement and tell me on your answering card the number that best fits your situation, now. There are no right or wrong answers.

These first statements ask you to **AGREE OR DISAGREE**

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
1. My spouse makes me feel confident in myself.....	1	2	3	4	5
2. In my relationship with my spouse, I get just as much as I give	1	2	3	4	5
3. My spouse shares similar views with me	1	2	3	4	5
4. I'm available to my spouse when he/she needs to talk	1	2	3	4	5
5. When I have helpful information, I try to share it with my spouse	1	2	3	4	5
6. I think I put more effort into my relationship with my spouse than he/she does	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
7. I can turn to my spouse for helpful advice about a problem	1	2	3	4	5
8. I don't mind lending money to my spouse if he/she needs it	1	2	3	4	5
9. I can talk openly about anything with my spouse	1	2	3	4	5
10. I'm satisfied with the give and take between me and my spouse	1	2	3	4	5
11. I can rely on my spouse for anything	1	2	3	4	5
12. My spouse is too pushy	1	2	3	4	5
13. I'm happy with the balance of how much I do for my spouse and how much he/she does for me	1	2	3	4	5
14. I can count on my spouse to make me feel better when I need it	1	2	3	4	5
15. When I need help, I get it from my spouse, and when he/she needs help, I give it back	1	2	3	4	5
16. My spouse gets mad if we have different opinions	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
17. It's safe for me to reveal my weaknesses to my spouse	1	2	3	4	5
18. My spouse stands by me through good and bad times.....	1	2	3	4	5
19. My spouse really helps out in an emergency	1	2	3	4	5
20. I can't count on my spouse	1	2	3	4	5
21. If I need help, all I have to do is ask my spouse	1	2	3	4	5
22. I have enough opportunity to talk things over with my spouse.....	1	2	3	4	5

THESE NEXT STATEMENTS ASK YOU **HOW OFTEN** SOMETHING HAPPENS

	NEVER	ALMOST NEVER	SOMETIMES	FAIRLY OFTEN	VERY OFTEN
23. I have enjoyable times with my spouse	1	2	3	4	5
24. I spend time doing things for my spouse when I'd rather not	1	2	3	4	5

	NEVER	ALMOST NEVER	SOMETIMES	FAIRLY OFTEN	VERY OFTEN
25. My spouse invades my privacy	1	2	3	4	5
26. I let my spouse know that I appreciate him/her	1	2	3	4	5
27. I am embarrassed by what my spouse does	1	2	3	4	5
28. My spouse comes to me for a boost in his/her spirits	1	2	3	4	5
29. My spouse tends to take advantage of me	1	2	3	4	5
30. My spouse is a burden to me	1	2	3	4	5
31. I tell my spouse when I think he/she is great	1	2	3	4	5
32. I wish my spouse was more sensitive to my needs	1	2	3	4	5
33. My spouse makes me do things I don't want to do	1	2	3	4	5
34. My spouse comes to me for advice	1	2	3	4	5
35. There is tension between me and my spouse	1	2	3	4	5

	NEVER	ALMOST NEVER	SOMETIMES	FAIRLY OFTEN	VERY OFTEN
36. I have trouble pleasing my spouse	1	2	3	4	5
37. My spouse lets me know he/she believes in me	1	2	3	4	5
38. My spouse expects too much of me	1	2	3	4	5
39. I let my spouse know I care about him/her	1	2	3	4	5

Modified Version from:
Tilden, V. (1987). Interpersonal Relationships Inventory. Oregon Health Sciences University, School of Nursing.

MODIFIED IPRI
French Version

Les relations que les gens entretiennent avec leur conjoint peuvent avoir des aspects positifs et négatifs. Je vais vous lire des énoncés qui décrivent certaines caractéristiques des relations conjugales en général. Ecoutez attentivement chaque énoncé et dites-moi le numéro sur votre carte-réponse qui correspond le mieux à votre situation actuelle. Il n'y a pas de bonnes ou de mauvaises réponses.

INDIQUER VOTRE **ACCORD OU VOTRE DESACCORD**

AVEC LES ENONCES SUIVANTS

1. Mon Conjoint me donne confiance en moi

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN DESACCORD NI EN ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3	4	5

2. Dans ma relation avec mon conjoint, je reçois autant que je donne

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN DESACCORD NI EN ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3	4	5

3. Mon conjoint partage les mêmes opinions que moi

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN DESACCORD NI EN ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3	4	5

4. Je suis disponible lorsque mon conjoint a besoin de parler

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2		3	4	5

5. Lorsque je détiens une information importante, j'essaie de la partager avec mon conjoint

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2		3	4	5

6. Je crois que je mets plus d'effort que mon conjoint dans notre vie commune

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2		3	4	5

7. Lorsque j'ai un problème, je peux me fier sur mon conjoint pour obtenir des conseils

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2		3	4	5

8. Cela ne me dérange pas de prêter de l'argent à mon conjoint s'il (ou elle) en a besoin

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2		3	4	5

9. Je peux discuter de n'importe quoi avec mon conjoint

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2		3	4	5

10. Je suis satisfait/e des échanges que j'ai dans ma vie de couple (c'est-à-dire je suis satisfait/e de ce que je donne et de ce que je reçois)

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

11. Je peux compter sur mon conjoint pour n'importe quoi

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

12. Mon conjoint veut toujours arriver à ses fins

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

13. Je suis heureux/se du partage qui existe entre ce que je fais pour mon conjoint et ce qu'il/elle fait pour moi.

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

14. Je peux compter sur mon conjoint pour me remonter le moral lorsque j'en ai besoin

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

15. Lorsque j'ai besoin d'aide, je l'obtiens de mon conjoint. En retour, lorsqu'il (ou elle) a besoin d'aide, je lui en donne.

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

16. Mon conjoint se fâche lorsque nous avons des opinions différentes

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

17. Je n'ai pas peur de parler de mes défauts avec mon conjoint

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

18. Mon conjoint me soutien dans les bons et les mauvais moments

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

19. En cas d'urgence, mon conjoint m'aide vraiment

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

20. Je ne peux pas compter sur mon conjoint

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

21. Lorsque j'ai besoin d'aide, je n'ai qu'à demander a mon conjoint

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

22. J'ai suffisamment l'occasion de parler avec mon conjoint pour régler des choses

FORTEMENT EN DESACCORD	EN DESACCORD	NI EN NI EN	DESACCORD ACCORD	D'ACCORD	FORTEMENT D'ACCORD
1	2	3		4	5

LES PROCHAINS ENONCES VOUS DEMANDENT A **QUELLE FREQUENCE** CERTAINES SITUATIONS VOUS ARRIVENT

23. J'ai du bon temps avec mon conjoint

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

24. Je passe mon temps à faire des choses pour mon conjoint lorsque je ne devrais pas

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

25. Mon conjoint dérange mon intimité

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

26. Je laisse savoir à mon conjoint que je l'apprécie

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

27. Je suis gêné du comportement de mon conjoint

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

28. Mon conjoint vient à moi lorqu'il/elle a besoin qu'on lui remonte le moral

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

29. Mon conjoint a tendance à prendre avantage de moi

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

30. Mon conjoint est un fardeau pour moi

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

31. Lorsque mon conjoint est gentil, je le lui dis

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

32. J'aimerais que mon conjoint soit plus sensible à mes besoins

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

33. Mon conjoint m'oblige à faire des choses que je ne veux pas faire

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

34. Mon conjoint vient à moi lorsqu'il/elle a besoin d'un conseil

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

35. Ma relation avec mon conjoint est tendue

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

36. J'ai de la difficulté à faire plaisir à mon conjoint

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

37. Mon conjoint me laisse savoir qu'il croit en moi

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

38. Mon conjoint a des attentes trop grandes envers moi

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

39. Je laisse savoir à mon conjoint que je me préoccupe de lui/d'elle

JAMAIS	PRESQUE JAMAIS	PARFOIS	ASSEZ SOUVENT	TRES SOUVENT
1	2	3	4	5

APPENDIX C

Family Crisis Oriented Personal Evaluation Scales (F-Copes)

(English and French Versions)

Permission to Use the F-Copes

F-COPES
FAMILY CRISIS ORIENTED PERSONAL SCALES
(McCubbin, H.I., Olson, D.H. & Larsen, A.S., 1987)

PURPOSE:

The Family Crisis Oriented Personal Evaluation Scales is designed to record problem-solving attitudes and behaviour which families develop to respond to problems or difficulties.

DIRECTIONS:

Decide how well each statement describes your attitudes and behaviours in response to problems or difficulties. If the statement describes your response very well, then select the number 5 on your answering card, indicating that you **STRONGLY AGREE**; if the statement does not describe your response at all, select number 1 indicating that you **STRONGLY DISAGREE**; if the statement describes your response to some degree, select number 2, 3, or 4 to indicate how much you agree or disagree with the statement.

WHEN WE FACE PROBLEMS OR DIFFICULTIES IN OUR FAMILY, WE RESPOND BY:

1. SHARING OUR DIFFICULTIES WITH RELATIVES

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

2. SEEKING ENCOURAGEMENT AND SUPPORT FROM FRIENDS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

3. KNOWING WE HAVE THE POWER TO SOLVE MAJOR PROBLEMS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

WHEN WE FACE PROBLEMS OR DIFFICULTIES IN OUR FAMILY, WE RESPOND BY:

4. SEEKING INFORMATION AND ADVICE FROM PERSONS IN OTHER FAMILIES WHO HAVE FACED THE SAME OR SIMILAR PROBLEMS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

5. SEEKING ADVICE FROM RELATIVES (BROTHERS, SISTERS, CHILDREN, ETC)

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

6. SEEKING ASSISTANCE FROM COMMUNITY AGENCIES AND PROGRAMS DESIGNED TO HELP FAMILIES IN OUR SITUATION

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

7. KNOWING THAT WE HAVE THE STRENGTH WITHIN OUR OWN FAMILY TO SOLVE OUR PROBLEMS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

8. RECEIVING GIFTS AND FAVORS FROM NEIGHBORS (E.G. FOOD, TAKING IN MAIL, ETC)

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

9. SEEKING INFORMATION AND ADVICE FROM THE FAMILY DOCTOR

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

WHEN WE FACE PROBLEMS OR DIFFICULTIES IN OUR FAMILY, WE RESPOND BY:

10. ASKING NEIGHBORS FOR FAVORS AND ASSISTANCE

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

11. FACING THE PROBLEMS "HEAD-ON" AND TRYING TO GET SOLUTION RIGHT AWAY

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

12. WATCHING TELEVISION

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

13. SHOWING THAT WE ARE STRONG

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

14. ATTENDING CHURCH/SYNAGOGUE SERVICES

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

15. ACCEPTING STRESSFUL EVENTS AS A FACT OF LIFE

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

16. SHARING CONCERNS WITH CLOSE FRIENDS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

WHEN WE FACE PROBLEMS OR DIFFICULTIES IN OUR FAMILY, WE RESPOND BY:

17. KNOWING LUCK PLAYS A BIG PART IN HOW WELL WE ARE ABLE TO SOLVE FAMILY PROBLEMS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

18. EXERCISING WITH FRIENDS TO STAY FIT AND REDUCE TENSION

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

19. ACCEPTING THAT DIFFICULTIES OCCUR UNEXPECTEDLY

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

20. DOING THINGS WITH RELATIVES (GET-TOGETHERS, DINNERS, ETC.)

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

21. SEEKING PROFESSIONAL COUNSELLING AND HELP FOR FAMILY DIFFICULTIES

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

22. BELIEVING WE CAN HANDLE OUR OWN PROBLEMS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

WHEN WE FACE PROBLEMS OR DIFFICULTIES IN OUR FAMILY, WE RESPOND BY:

23. PARTICIPATING IN CHURCH/SYNAGOGUE ACTIVITIES

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

24. DEFINING THE FAMILY PROBLEM IN A MORE POSITIVE WAY SO THAT W DO NOT BECOME TOO DISCOURAGED

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

25. ASKING RELATIVES HOW THEY FEEL ABOUT PROBLEMS WE FACE

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

26. FEELING THAT NO MATTER WHAT WE DO TO PREPARE, WE WILL HAVE DIFFICULTY HANDLING PROBLEMS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

27. SEEKING ADVICE FROM A MINISTER

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agr
1	2	3	4	5

28. BELIEVING IF WE WAIT LONG ENOUGH, THE PROBLEM WILL GO AWAY

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

WHEN WE FACE PROBLEMS OR DIFFICULTIES IN OUR FAMILY, WE RESPOND BY:

29. SHARING PROBLEMS WITH NEIGHBORS

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

30. HAVING FAITH IN GOD

Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1	2	3	4	5

Source: McCubbin, H. & Thompson, A. (1987). Family Assessment Inventories for Research and Practice (pp. 206-207) University of Wisconsin-Madison

F-COPES
French Version

Ce questionnaire a été conçu dans le but de recueillir des données sur les attitudes et les comportements que les familles adoptent lorsqu'elles ont à faire face à des problèmes ou à des difficultés.

CONSIGNES

Je vais vous demander de me dire à quel point vous êtes d'accord avec les énoncés que je vais vous lire. Si l'énoncé décrit très bien les comportements ou les attitudes de votre "couple", lorsque vous et votre conjoint faites face a un problème ou une difficulté, votre réponse sera le numéro 5 sur votre carte-réponse, indiquant que vous êtes **FORTEMENT EN ACCORD**; si l'énoncé ne décrit pas du tout ce que vous et votre conjoint faites lorsque vous rencontrez un problème, votre réponse sera le numéro 1 indiquant que vous êtes **FORTEMENT EN DESACCORD**. Si l'énoncé décrit en partie les comportements ou les attitudes de votre couple, choissisez les numéros 2, 3 ou 4 afin d'indiquer à quel point vous êtes en accord ou en déaccord avec l'éoncé.

EN TANT QUE COUPLE, LORSQUE NOUS FAISONS FACE A DES PROBLEMES OU DES DIFFICULTES NOUS:

1. PARTAGEONS NOS DIFFICULTES AVEC NOTRE FAMILLE (ENFANTS, PETITS-ENFANTS, SOEURS, FRERES ETC.)

fortement en désaccord	modérément en désaccord	pas en accord ni en désaccord	modérement d'accord	fortement d'accord
1	2	3	4	5

2. RECHERCHONS DE L'ENCOURAGEMENT ET DU SOUTIEN DE NOS AMIS

fortement en désaccord	modérément en désaccord	pas en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

3. RECONNAISSONS QUE NOUS AVONS LE POTENTIEL POUR RESOUDRE LES PROBLEMES MAJEURS

fortement en désaccord	modérément en désaccord	pas en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

4. DEMANDONS DE L'INFORMATION ET DES CONSEILS A D'AUTRES FAMILLES QUI ONT FAIT FACE A DES PROBLEMES SEMBLABLES

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

5. DEMANDONS DES CONSEILS A NOTRE FAMILLE (ENFANTS, PETITS-ENFANTS...)

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

EN TANT QUE COUPLE, LORSQUE NOUS FAISONS FACE A DES PROBLEMES OU DES DIFFICULTES NOUS:

6. DEMANDONS DE L'AIDE DES SERVICES ET PROGRAMMES COMMUNAUTAIRES CONCUS POUR AIDER LES FAMILLES VIVANT UNE SITUATION COMME LA NOTRE

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

7. SAVONS QUE NOUS AVONS LA FORCE DE RESOUDRE NOS PROBLEMES

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

8. COMPTONS SUR LA CHARITE ET LES BONNES GRACES DES VOISINS (NOURRITURE, SERVICES ETC)

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

9. DEMANDONS DE L'INFORMATION ET DES CONSEILS A NOTRE MEDECIN DE FAMILLE

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

10. DEMANDONS DES SERVICES ET DE L'ASSISTANCE AUX VOISINS

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

EN TANT QUE COUPLE, LORSQUE NOUS FAISONS FACE A DES PROBLEMES OU DES DIFFICULTES NOUS:

11. FAISONS FACE AUX PROBLEMES DIRECTEMENT ET NOUS TENTONS DE TROUVER UNE SOLUTION IMMEDIATEMENT

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

12. REGARDONS LA TELEVISION

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

13. MONTRONS QUE NOUS SOMMES "FORTS"

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

14. ASSISTONS A LA MESSE

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

15. ACCEPTONS LES EVENEMENTS STRESSANTS COMME ETANT INEVITABLES

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

16. PARTAGEONS NOS SOUCIS AVEC NOS PROCHES AMIS

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

EN TANT QUE COUPLE, LORSQUE NOUS FAISONS FACE A DES PROBLEMES OU DES DIFFICULTES NOUS:

17. SAVONS QUE LA CHANCE JOUE UN GRAND ROLE DANS LA RESOLUTION DE NOS PROBLEMES FAMILIAUX

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

18. FAISONS DE L'EXERCICE AVEC LES AMIS POUR RESTER EN FORME ET REDUIRE NOTRE STRESS

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

19. ACCEPTONS QUE LES PROBLEMES OU LES DIFFICULTES SURVIENNENT DE FACON INATTENDUE

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

20. FAISONS DES ACTIVITES SOCIALES AVEC LA PARENTE (RENCONTRES, REPAS ETC)

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

21. CONSULTONS DES PROFESSIONNELS POUR NOUS AIDER

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

EN TANT QUE COUPLE, LORSQUE NOUS FAISONS FACE A DES PROBLEMES OU DES DIFFICULTES NOUS:

22. CROYONS QUE NOUS POUVONS PRENDRE EN MAIN NOS PROPRES PROBLEMES

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

23. PARTICIPONS A DES ACTIVITES RELIGIEUSES

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

24. TENTONS DE VOIR LE PROBLEME DE FACON PLUS POSITIVE DE SORTE QUE NOUS SOYIONS MOINS DECOURAGES

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

25. DEMANDONS AUX MEMBRES DE NOTRE PARENTE LEURS OPINIONS A PROPOS DE NOS PROBLEMES

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

26. SENTONS QUE QUOIQUE NOUS FASSIONS, NOUS AURONS DE LA DIFFICULTE A PRENDRE EN MAIN NOTRE SITUATION

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

EN TANT QUE COUPLE, LORSQUE NOUS FAISONS FACE A DES PROBLEMES OU DES DIFFICULTES NOUS:

27. DEMANDONS L'AVIS D'UN PRETRE

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

28. CROYONS QUE SI NOUS ATTENDONS SUFFISAMMENT LONGTEMPS, LE PROBLEME SE RESOUDRA DE LUI-MEME

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

29. PARTAGEONS NOS PROBLEMES AVEC LES VOISINS

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

30. CROYONS EN DIEU

fortement en désaccord	modérément en désaccord	ni en accord ni en désaccord	modérément d'accord	fortement d'accord
1	2	3	4	5

APPENDIX D

Cantril Self-Anchoring Ladder (English and French Versions)

SELF-ANCHORING SCALING
FOR SELF-ASSESSED HEALTH
(Cantril, 1965)

N.B. **USE ALSO THE TAPE RECORDER FOR THESE QUESTIONS**

1. E: WOULD YOU PLEASE DESCRIBE WHAT WOULD BE FOR YOU (AT YOUR AGE) **THE VERY BEST** HEALTH CONDITION?

   F: SI L'ON VOUS DEMANDAIT DE DECRIRE CE QUE SERAIT POUR VOUS (A VOTRE AGE) **"ETRE DANS LE MEILLEUR"** ETAT DE SANTE POSSIBLE, QUE DIRIEZ-VOUS?

   ---

2. E: WOULD YOU PLEASE DESCRIBE WHAT WOULD BE FOR YOU (AT YOUR AGE) THE **VERY WORST** HEALTH CONDITION?

   F: POURRIEZ-VOUS DECRIRE CE QUE SERAIT POUR VOUS (A VOTRE AGE) LE **PIRE** DES ETATS DE SANTE POSSIBLE?

   ---

3. E: IMAGINE THAT THE **BEST** AND **WORST** POSSIBLE HEALTH CONDITION YOU JUST DESCRIBED FOR YOU ARE THE END POINTS OF THE FOLLOWING SCALE, THE **BEST** AT THE **TOP** AND THE **WORST** AT THE **BOTTOM**, WHERE ON THIS LADDER WOULD YOU SAY YOU ARE **NOW?**

   F: IMAGINEZ POUR UN INSTANT QUE LE **MEILLLEUR** ET LE **PIRE** DES ETATS DE SANTE (QUE VOUS VENEZ DE DECRIRE), SOIENT LES EXTREMITES DE L'ECHELLE SUIVANTE, LE **MEILLEUR AU HAUT** DE L'ECHELLE ET LE **PIRE AU BAS**, OU VOUS SITUERERIEZ-VOUS SUR CETTE ECHELLE EN CE QUI CONCERNE VOTRE ETAT DE SANTE **ACTUEL**?

10

9

8

7

6

5

4

3

2

1

0

APPENDIX E

Life Satisfaction Index (LSI-Z)

(English and French Versions)

LIFE SATISFACTION INDEX-Z
(Wood, Wylie & Schaefer, 1969)

Here are some statements about life in general that people feel differently about. Could you please tell me on your answering card if you **AGREE**, **DISAGREE** or you are not sure one way or the other (?).

	AGREE	**DISAGREE**	**?**
1. As I grow older, things seem better than I thought they would be			
2. I have gotten more of the breaks in life than most of the people I know			
3. This is the dreariest time of my life			
4. I am just as happy as when I was younger			
5. These are the best years of my life			
6. Most of the things I do are boring or monotonous			
7. The things I do are as interesting to me as they ever were			
8. As I look back on my life, I am fairly well satisfied			
9. I have made plans for things I'll be doing a month or a year from now			
10. When I think back over my life, I didn't get most of the important things I wanted			
11. Compared to other people, I get down in the dumps too often			
12. I've gotten pretty much what I expected out of life			

	AGREE	DISAGREE	?
13. In spite of what people say, the lot of the average man is getting worse, not better			

Source: Wood, V., Wylie, M. & Sheafer, B. (1969). An analysis of a short self-report measure of life satisfaction: Correlation with rater judgments. Journal of Gerontology 24, 465-469.

LSI-Z

French Version

Voici certains commentaires sur la vie en général. Pour chacun de ces commentaires, pouvez-vous m'indiquer sur votre carte-réponse si vous êtes **D'ACCORD, EN DESACCORD, ou INCERTAIN?**

1) EN VIEILLISSANT, LES CHOSES VONT MIEUX QUE JE M'Y ATTENDAIS

Accord ( ) Désaccord ( ) Incertain ( )

2) J'AI EU PLUS DE CHANCE DANS MA VIE QUE LA PLUPART DES GENS QUE JE CONNAIS

Accord ( ) Désaccord ( ) Incertain ( )

3) JE TRAVERSE PRESENTEMENT LA PERIODE LA PLUS TRISTE DE MA VIE

Accord ( ) Désaccord ( ) Incertain ( )

4) JE SUIS AU MOINS AUSSI HEUREUX/SE QUE LORSQUE J'ETAIS PLUS JEUNE

Accord ( ) Désaccord ( ) Incertain ( )

5) JE VIS ACTUELLEMENT LES MEILLEURES ANNEES DE MA VIE

Accord ( ) Désaccord ( ) Incertain ( )

6) LA PLUPART DES ACTIVITES QUE JE FAIS SONT ENNUYEUSES ET MONOTONES

Accord ( ) Désaccord ( ) Incertain ( )

7) LES CHOSES QUE JE FAIS SONT AUSSI INTERESSANTES QU'ELLES L'ONT TOUJOURS ETE

Accord ( ) Désaccord ( ) Incertain ( )

8) QUAND JE PENSE A MA VIE PASSEE, JE SUIS PLUTOT SATISFAIT

Accord ( ) Désaccord ( ) Incertain ( )

9) JE FAIS DES PROJETS POUR DES CHOSES QUE J'AIMERAIS FAIRE DANS UN MOIS OU DANS UN AN

Accord ( ) Désaccord ( ) Incertain ( )

10) LORSQUE JE PENSE A MA VIE PASSEE, JE TROUVE QUE JE N'AI PAS OBTENU LA PLUPART DES CHOSES QUE JE DESIRAIS

Accord ( ) Désaccord ( ) Incertain ( )

11) COMPARATIVEMENT AUX AUTRES, JE SUIS TROP SOUVENT DEPRIME

Accord ( ) Désaccord ( ) Incertain ( )

12) J'AI OBTENU A PEU PRES TOUT CE QUE J'ATTENDAIS DE LA VIE

Accord ( ) Désaccord ( ) Incertain ( )

13) MALGRE CE QUE LES GENS DISENT, LE SORT DE L'HOMME MOYEN NE S'AMELIORE PAS, IL EMPIRE

Accord ( ) Désaccord ( ) Incertain ( )

APPENDIX F

Visual Analogue Scale and Open-Ended Question

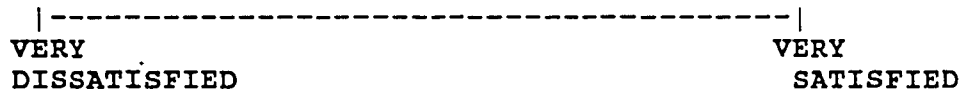
Measuring Marital Satisfaction

(English and French Versions)

MARITAL SATISFACTION-VISUAL ANALOGUE SCALE

E. EACH OF US HAS A PERSONAL OPINION ABOUT THE QUALITY OF OUR LIFE. FOR MARRIED PERSONS, EVERYDAY LIFE WITH THEIR SPOUSE IS AN IMPORTANT ASPECT OF THEIR LIVES. HOW MUCH ARE YOU SATISFIED WITH YOUR DAILY LIFE WITH YOUR SPOUSE RIGHT NOW?

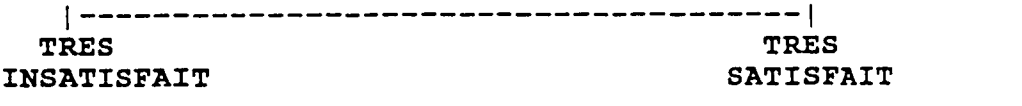
ON THE FOLLOWING LINE, PLACE A VERTICAL MARK AT A POINT MOST APPROPRIATE TO YOUR EVALUATION AT THE MOMENT.



French Version

F. NOUS AVONS TOUS UNE IDEE DE NOTRE QUALITE DE VIE. POUR LES GENS MARIES, LA VIE DE COUPLE EST UN ASPECT IMPORTANT DE LA VIE DE TOUS LES JOURS. COMMENT EVALUERIEZ-VOUS VOTRE SATISFACTION EN RAPPORT A VOTRE VIE DE COUPLE A L'HEURE ACTUELLE?

SUR LA LIGNE SUIVANTE, PLACER UNE MARQUE VERTICALE A L'ENDROIT QUI CORRESPOND LE MIEUX A VOTRE EVALUATION ACTUELLE.



OPEN-ENDED QUESTION

WHY?

POURQUOI?

APPENDIX G

Functional Ability Measure

(English and French Versions)

FUNCTIONAL ABILITY MEASURE
(Chappel & Strain, 1985)

DIRECTIONS TO THE INTERVIEWER:

RATE THE CLIENT ON HIS/HER FUNCTIONAL ABILITY TO PERFORM THE TASK WITHIN THE CURRENT LIVING ARRANGEMENT. CONSIDER THE CLIENT STRENGTHS WHEN APPROPRIATE. BE SURE TO NOTE THE CLIENT'S **ABILITY** TO PERFORM THE TASK RATHER THAN HIS/HER TENDENCY TO IN FACT DO THE TASK.

Now, I have some questions about your ability to carry on different activities. I am interested in your **capability**, not whether or not you actually do them.

1. Can you use the telephone?

    1. Yes, without help (including looking up numbers)
    2. Yes, can dial if number is available; no phone, but client has easy access to phone and has memorized or has easy access to important numbers
    3. Only answers phone; uses phone only with help, cannot read
    4. Can't use phone at all
    9. Missing Value (MV)

(IF THE CLIENT CANNOT LOOK UP NUMBERS BECAUSE OF ILLITERACY, SCORE THE CLIENT AS 1.)

2. Are you able to shop for groceries, clothing?

(SHOPPING IS DEFINED AS PURCHASING ITEMS FOR PERSONAL NEEDS SUCH AS FOOD, CLOTHING, AND MEDICINE. SHOPPING DOES NOT HAVE TO INCLUDE EXCEPTIONAL ITEMS SUCH AS FURNITURE. SHOPPING INCLUDES THE ACTUAL PURCHASING AND RELATED ACTIVITIES SUCH AS TRANSPORTATION AND CARRYING PURCHASES)

    1. Yes, without help; able to go to the stores alone, able to carry purchases home with or without a car
    2. Yes, but need some help usually, can do regular shopping alone but may need assistance with carrying, transportation,or delivery to home

3. Always need help, can shop, but cannot go alone, has no transportation or cannot carry purchases

4. Cannot shop at all

9. MV

3. Can you prepare your own meals? Do you have difficulty preparing and eating your own meals?

(DETERMINE IF THE CLIENT CAN PREPARE A NUTRITIOUS, HOT MEAL).

1. Yes, plan and cook; can plan and prepare nutritional meals as needed for daily living

2. Can prepare simple things; could use help but can prepare simple, cooked meals

3. Only with help; unable to prepare simple meals; cannot cook, although may heat water on stove

4. Completely unable to prepare meals

9. MV

4. Can you do household tasks, chores?

1. Yes, without help; able to perform all necessary tasks, including heavy chores such as vacuuming, changing bedding

2. Able to perform all necessary tasks except heavy chores such as vacuuming, changing bedding, laundry

3. Able to perform only light housekeeping tasks such as dusting, dishes, pulling covers up on bed

4. Cannot do housekeeping

9. MV

5. Can you handle your own money; deposit cheques, pay bills etc.?

1. Can handle all money; cash cheques, pay bills etc.

2. Can handle money; may need help in paying bills because of transportation, or needing cheque cashed, etc.

3. Can handle coins, small bills; does not pay bills; depends on help from others

4. Cannot handle money at all; completely dependent on others

9. MV

6. Can you dress and undress yourself?

1. Yes, without any help

2. May experience difficulty or pain; can button or zipper when necessary; assistance wculd make task easier

3. Can dress only with help; always needs help with buttons, zippers, fastenings, shoes; does not wear underclothing due to difficulty in dressing

4. Completely unable to dress and undress

9. MV

7. Do you need help eating?

1. No help needed

2. Minimal help required; can feed self using silverware, pick up glass; occasional spills, pain or shaking; may need help cutting food but can bring to mouth

3. Great deal of help required; can feed self but has difficulty using silverware; liquids or soups need special attention; can eat finger foods only

4 Completely dependent (tubes, I.V., hand fed)

9. MV

8. Can you take a bath or shower?

1. Yes, no help required; client can physically bathe and can wash his/her hair

2. Client can bathe; may need help preparing bath, may need help getting out of tub (grab bars may be needed); shampooing is difficult, bathing may be painful; assistance would be beneficial but not absolutely necessary

3. Always needs special equipment or assistance; can physically bathe, but cannot get in and out of tub alone

4. Completely unable to bath self

9. MV

9. Do you need help walking?

1. No help required; can climb up and down stairs; able to manage on own both inside and outside

2. Some help with stairs, but walks without help

3. Always need help but can walk with help

4. Cannot walk even with help

9. MV

10. Do you need assistance using the toilet?

1. No help required

2. Some difficulty but can manage mostly on own

3. Only with help (needs special equipment)

4. Completely unable

9. MV

11. Do you need help taking out the trash or garbage?

1. No help required

2. With some difficulty

3. With help

4. Never(incapable)

9. MV

12. Do you need help taking medication or with routine health practice?

    1. No help required

    2. Sometimes need help

    3. Usually need help

    4. Completely dependent

    9. MV

Source: Chappel, N & Strain, L. (1985). Decision-Making among the Elderly and the Use of Health and Social Services. Interview Schedule (pp. 16-20). University of Manitoba: Centre on Aging.

QUESTIONNAIRE MESURANT LES HABILETES FONCTIONNELLES
French Version

CONSIGNES POUR L'INTERVIEWER: EVALUER LE REPONDANT SUR SES HABILITES A ACCOMPLIR LES TACHES SUIVANTES EN CONSIDERANT SES FORCES. IL EST IMPORTANT D'EVALUER LA **CAPACITE** DU REPONDANT A ACCOMPLIR LES TACHES ET NON LE FAIT QUE LE REPONDANT EFFECTUE OU NON LES TACHES PROPOSEES DANS SA VIE DE TOUS LES JOURS.

J'ai quelques questions à vous poser concernant votre capacité à effectuer différentes activités dans votre domicile. Je suis interessée à connaître votre capacité de faire ces activités et non à savoir si vous faites ou non ces activités dans votre vie de tous les jours.

1. Etes-vous **capable** de vous servir du téléphone?

   1. Oui, sans aide (même pour chercher un numéro dans l'annuaire)

   2. Oui, peut signaler si connait le numéro; ou n'a pas le téléphone mais accède facilement au téléphone et mémorise; ou est capable de trouver les numéros les plus importants dont il a besoin

   3. Ne peut que répondre au téléphone; Se sert du téléphone avec aide seulement; Ne peut lire les numéros de téléphone

   4. Ne peut absolument pas se servir du téléphone

   9. Pas de réponse

N.B. SI LE CLIENT NE PEUT PAS LIRE LES NUMEROS DE TELEPHONE CAR ILLETTRE, INSCRIVEZ 1.

2. Etes-vous **Capable** de magasiner pour vos vêtements, votre nourriture? (MAGASINER INCLUE L'ACHAT DES MARCHANDISES USUELLES ET LES ACTIVITES QUI Y SONT RELIEEES TELLES QUE TRANSPORTER DES PAQUETS)

   1. Oui, sans aide; capable d'aller seul au magasin, capable de rapporter les provisions à la maison avec ou sans voiture

2. Oui, mais a habituellement besoin d'aide. Capable seul d'aller acheter ce qu'il lui faut mais peut avoir besoin d'aide pour transporter les marchandises; ou fait livrer la marchandise à la maison

3. A toujours besoin d'aide. Peut magasiner mais ne peut se rendre seul au magasin. N'a pas de moyen de transport ou ne peut pas transporter les marchandises.

4. Incapable de magasiner

9. Pas de réponse

3. Etes-vous capable de préparer vos repas? Avez-vous de la difficulté à préparer vos propres repas? (EVALUER SI LE CLIENT EST CAPABLE DE PREPARER UN REPAS COMPLET).

1. Oui, planifie les repas et fait la cuisine; Est capable de planifier et de préparer des repas nutritifs

2. Peut préparer des repas simples; pourrait avoir besoin d'aide mais est capable de préparer de simples repas chauds.

3. Seulement avec aide; Incapable de préparer des repas simples; incapable de cuisiner mais peut faire bouillir de l'eau

4. Complètement incapable de préparer des repas

9. Aucune réponse

4. Pouvez-vous exécuter des tâches et des corvées ménagères?

1. Oui sans aide; Capable d'exécuter toutes les tâches incluant les lourdes corvées

2. Capable d'exécuter toutes les tâches nécessaires à l'exception des corvées lourdes telles que passer la balayeuse, changer les lits, faire le lavage)

3. Capable d'exécuter seulement des tâches ménagères légères telles que l'époussetage, la vaisselle, faire le lit

4. Incapable d'exécuter des tâches ménagères

9. Pas de réponses

5. Etes-vous capable de gérer votre argent, c'est-à-dire de déposer vos chèques, de payer vos comptes etc?

   1. Oui, seul; encaisse ses chèques, paie ses comptes etc.

   2. Oui, mais peut avoir besoin d'aide pour payer ses comptes ou encaisser ses chèques, faute de transport pour se déplacer

   3. Capable de gérer des petites sommes (monnaie, petits billets); ne paie pas ses comptes seul; dépend de l'aide des autres.

   4. Ne peut pas gérer son argent; complètement dépendant des autres.

   5. Aucune réponse

6. Etes-vous capable de vous habiller et de vous déshabiller seul?

   1. Oui, sans aide

   2. Peut avoir de la difficulté ou de la douleur; Peut boutonner ou remonter un fermoir lorsque nécessaire mais de l'aide faciliterait la tâche.

   3. Ne peut s'habiller qu'avec aide; a toujours besoin d'aide pour boutonner, remonter sa fermeture éclair, agrafer, attacher ses souliers

   4. Totalement incapable de s'habiller et de se déshabiller

   9. Pas de réponse

7. Avez-vous besoin d'aide pour manger?

   1. Aucun besoin d'aide

   2. Aide minimale requise; Peut s'alimenter avec des ustensiles, boit au verre; renverse occasionnellement de la nourriture à cause de la douleur ou d'un tremblement; Peut avoir besoin d'aide pour couper ses aliments

   3. Nécessite beaucoup d'aide; Peut s'alimenter seul mais a de la difficulté à utiliser des ustensiles surtout pour les liquides; Peut manger seul de la nourriture en bâtonnets

   4. Complètement dépendant

9. Pas de réponse

8. Etes-vous capable de prendre un bain ou une douche?

1. Oui, sans aide; le répondant est capable de se laver et de laver ses cheveux seul

2. Peut prendre son bain; Peut avoir besoin d'aide pour préparer son bain et sortir du bain (des barres d'appui peuvent être nécessaires); se laver les cheveux est difficile et se laver peut être douloureux; de l'aide serait utile mais pas absolument nécessaire

3. A toujours besoin d'un appareillage spécial ou de l'aide d'une personne; peut se laver mais ne peut pas entrer et sortir du bain seul

4. Totalement incapable de se laver au bain ou à la douche

9. Pas de réponse

9. Avez-vous besoin d'aide pour marcher?

1. Aucun besoin d'aide; peut monter et descendre les escaliers; Peut marcher seul à l'intérieur et à l'extérieur de la maison

2. A besoin d'aide pour monter et descendre les escaliers mais marche sans aide

3. A toujours besoin d'aide mais est capable de marcher avec aide

4. Ne peut marcher même avec aide

5. Pas de réponse

10. Avez-vous besoin d'aide pour aller à la toilette?

1. Aucun besoin d'aide

2. A quelques difficultés mais peut s'organiser seul la plupart du temps (a besoin de barres d'appui ou d'autres équipements spéciaux)

3. A toujours besoin d'aide

4. Totalement incapable d'aller à la toilette

5. Pas de réponse

11. Avez-vous besoin d'aide pour sortir les poubelles ou les déchets à l'extérieur?

1. Aucun besoin d'aide

2. Capable mais a quelques difficultés

3. A besoin d'aide

4. Incapable

5. pas de réponse

12. Avez-vous besoin d'aide pour prendre vos médicaments ou pour suivre les recommandations concernant votre santé?

1. Aucun besoin d'aide

2. A parfois besoin d'aide

3. A besoin d'aide la plupart du temps

4. Complètement dépendant

5. pas de réponse

APPENDIX H

Demographic and Background Variables Questionnaire

DEMOGRAPHIC AND BACKGROUND VARIABLES QUESTIONNAIRE

coding number:-------

GENDER: ------ MALE -------- FEMALE
SEXE : ------ HOMME -------- FEMME

AGE AT LAST BIRTHDAY: ----------
AGE AU DERNIER ANNIVERSAIRE: ---------

PLACE OF BIRTH: ----------
LIEU DE NAISSANCE: ----------

RELIGION: ----------
RELIGION: ----------

PRESENT OCCUPATION: ----------
TRAVAIL ACTUEL: ----------

MOST IMPORTANT OCCUPATION IN YOUR LIFE----------
TRAVAIL OCCUPE LE PLUS LONGTEMPS AU COURS DE VOTRE VIE --------

SOURCE OF INCOME: ----------
SOURCE DE REVENU ACTUEL: ----------

YEARS OF EDUCATION ----------
NIVEAU DE SCOLARITE (DERNIERE ANNEE SCOLAIRE COMPLETEE) -------

NUMBER OF YEARS MARRIED WITH YOUR PRESENT SPOUSE: ----------
FIRST MARRIAGE: ------ SECOND MARRIAGE: ----- THIRD: ------
NUMBER OF CHILDREN: -----

NOMBRE D'ANNEES DE MARIAGE AVEC VOTRE CONJOINT ACTUEL:--------
PREMIER MARIAGE: -------- DEUXIEME: ----- TROISIEME:--------
NOMBRE D'ENFANTS:--------

HOW MANY OF YOUR CLOSE RELATIVES DO YOU SEE OR CONTACT REGULARLY? (every week or two) ----------

COMBIEN AVEZ-VOUS DE PROCHES PARENTS AVEC QUI VOUS COMMUNIQUEZ REGULIEREMENT? (A toutes les semaines ou a toutes les deux semaines) ----------

HOW MANY PEOPLE (FRIENDS AND NEIGHBORS) DO YOU SEE REGULARLY? (once or more every week) ----------

COMBIEN AVEZ-VOUS D'AMIS ET DE VOISINS QUI VOUS VOYEZ REGULIEREMENT
(une a plusieurs fois par semaines) ----------

APPENDIX I

The Geriatric Social Readjustment Rating Scale (GSRRS)

(English and French Versions)

Scoring Sheet for the GSRRS

THE GERIATRIC SOCIAL READJUSTMENT RATING SCALE (GSRRS)

DIRECTIONS:

I will read you a list of events and situations which can occur in everyday life. Could you please tell me if you have experienced any of these events or situations in the last six months.

-----1 Death of Spouse
-----2 Institutionalization
-----3 Death of Close Family Member
-----4 Major Personal Injury or Illness
-----5 Being Fired from Work
-----6 Divorce
-----7 Major Change in Financial State
-----8 Retirement
-----9 Marital Separation from Mate
-----10 Eyesight Failing
-----11 Marriage
-----12 Death of Close Friend
-----13 Change in Health or Behaviour of Family Member
-----14 Major Change in Gratifying Activities
-----15 Hearing Failing
-----16 Change in Sexual Behavior
-----17 Change in Responsibilities at Work
-----18 Change in Residence other than Institutionalization
-----19 Painful Arthritis
-----20 Feeling of Slowing Down
-----21 Changing to Different Line of Work
-----22 Spouse Ceasing Work Outside Home
-----23 Change in Living Conditions or Environment
-----24 Marital Reconciliation with Mate
-----25 Change in Social Activities
-----26 Losing Driver's License
-----27 Change in Living Composition
-----28 Reaching 65
-----29 Reaching 70
-----30 Major Change in Working Hours or Conditions
-----31 Troubles with the Boss
-----32 Holidays and Anniversaries
-----33 Argument with Children
-----34 Argument with Spouse
-----35 Vacation

Source: Amster, L. & Krauss, H. (1974). The relationship between life crises and mental deterioration in old age. International Journal of Aging and Human Development, 5, 51-55.

THE GERIATRIC SOCIAL READJUSTMENT RATING SCALE (GSRRS)
French version

CONSIGNES:

Je vais vous lire une liste d'évènements et de situations qui peuvent arriver dans la vie quotidienne. J'aimerais que vous m'indiquiez les évènements ou les situations que vous avez vécus au cours des six derniers mois.

------1 Décès du conjoint
------2 Entrée en institution
------3 Décès d'un parent proche
------4 Blessure ou maladie importante
------5 Congédiement de votre travail
------6 Divorce
------7 Changement majeur de votre situation financière
------8 Retraite
------9 Séparation de votre conjoint
------10 Diminution de votre vision
------11 Mariage
------12 Décès d'un ami cher
------13 Changement dans l'état de santé ou le comportement d'un membre de votre famille
------14 Changement majeur dans vos activités préférées
------15 Problème d'audition
------16 Changement dans votre vie sexuelle
------17 Changement dans vos responsabilités au travail
------18 Déménagement (autre qu'une institutionnalisation)
------19 Douleurs arthritiques
------20 Sensation de ralentissement dans ce que vous faites
------21 Changement d'orientation dans votre travail
------22 Cessation d'emploi à l'extérieur de votre conjoint
------23 Changement dans vos conditions de vie ou dans votre environnment
------24 Réconciliation avec votre conjoint
------25 Changements dans vos activités sociales
------26 Perte de votre permis de conduire
------27 Changement dans le nombre de personnes qui vivent avec vous quotidiennement
------28 Changement d'âge: vous avez eu 65 ans
------29 Changement d'âge: vous avez eu 70 ans
------30 Changements majeurs dans vos heures ou vos conditions de travail
------31 Difficultés avec votre patron
------32 Congés et anniversaires
------33 Dispute avec vos enfants
------34 Dispute avec votre conjoint
------35 Vacances

SCORING SHEET FOR THE GSRRS

RANK	LIFE EVENT	WEIGHT
1	Death of Spouse	125
2	Institutionalization	82
3	Death of Close family Member	67
4	Major Personal Injury or Illness	66
5	Being Fired from Work	64
6	Divorce	61
7	Major Change in Financial State	56
8	Retirement	55
9	Marital Separation from Mate	54
10	Eyesight failing	51
11	Marriage	50
12	Death of Close Friend	50
13	Major Change in Health or Behavior of Family Member	47
14	Major Change in Gratifying Activities	46
15	Hearing Failing	46
16	Change in Sexual behavior	45
17	Change in Responsibilities at work	43
18	Change in Residence other than Institutionalization	43
19	Painful Arthritis	42
20	Feeling of Slowing Down	41
21	Changing to different line of work	41
22	Spouse ceasing work outside home	40
23	Change in Living Conditions or Environment	40
24	Marital Reconciliation with mate	39
25	Change in Social Activities	38
26	Losing driver's license	34
27	Change in Living Composition	33
28	Reaching 65	32
29	Reaching 70	31
30	Major Change in Working Hours or Conditions	28
31	Troubles with the Boss	28
32	Holidays and Anniversaries	23
33	Argument with Children	22
34	Argument with spouse	20
35	Vacation	16

APPENDIX J

Written Consent Form

(English and French Versions)

WRITTEN CONSENT FORM
English Version

The research project has been explained to me. I understand that if I agree to participate, I will answer some questions concerning my daily life and my health. The interview will be in my home and will take about one hour.

I further understand that:

All information is stricly confidential and my identity will not be revealed

My participation is voluntary

My decision to participate will not affect the care/services I receive from the agency.

I am free to withdraw my consent and to discontinue my participation in the project at any time without explanation

Any questions I have about the project will be answered

I understand that while I am encouraged to answer all questions, I am not obliged to do so.

On the basis of the above statements I agree to participate in this project.

---------- --------
Participant's Signature Date

---------- --------
Witness Date

FORMULE DE CONSENTEMENT ECRIT
French Version

Ce projet de recherche m'a été expliqué. Je sais que si j'accepte d'y participer, j'aurai à répondre verbalement à certaines questions concernant mon vécu quotidien et ma santé. Cette entrevue aura lieu à mon domicile et durera environ une heure.

De plus, je reconnais que:

Toute les informations que je fournirai seront strictement confidentielles et que mon identité ne sera pas révélée

Ma participation est volontaire

Ma décision de participer n'affectera en rien les soins ou les services que je reçois

Je suis libre de me désister et de cesser de participer à e projet à n'importe quel moment et ce, sans explication

J'obtiendrai réponse à toute question que j'aurai concernant ce projet

Même si l'on m'encourage à répondre à toutes les questions, je n'y suis pas obligé

Après avoir pris connaissance de ces déclarations, j'accepte de participer à ce projet.

---------- -------
Signature du Participant Date

---------- -------
Temoin Date

APPENDIX K

Age Distribution of the Sample

Age Distribution of the Sample (N=270)

Age Group	n Men	n Women	n Total	%
65-69	41	62	103	38.1
70-74	48	44	92	34.0
75-79	25	19	44	16.2
80-84	14	8	22	8.1
85-89	6	1	7	2.5
90-	1	1	2	.7
Total	135	135	270	100

APPENDIX L

Means, Standard Deviations and Range of Scores

For Each Study Variable

Means, Standard Deviations and Range of Scores For The Study Variables (N=270)

Dimensions	Theoretical Range	Mean	S.D.	Range
Conjugal Support				
Availability	13-65	50.1	10.33	14-65
Reciprocity	13-65	47.7	8.4	20-63
Conflict	13-65	28.2	10.1	13-60
Family Coping				
Reframing	8-40	31.0	6.7	8-40
Passive Appraisal	4-20	13.8	3.3	5-20
Acquiring Social Support	9-45	20.5	7.4	9-44
Seeking Spiritual Support	4-20	12.8	4.3	4-20
Mobilizing the Family to Acquire and Accept help	4-20	10.4	3.5	4-20
Well-Being				
Self-Assessed Health	0-10	7.6	2.1	0-10
Life-Satisfaction	0-26	18.5	5.4	3-26
Marital Satisfaction	0-100	75.4	23.6	0-100
Extraneous Variables				
Functional Ability	12-48	13.8	4.0	12-40
Network Size	0-99	18.0	17.1	0-81
Level of Stress	0-1599	199.6	106.2	0-521

APPENDIX M

Correlation Matrices for Men and Women Including All Variables

Variable Correlation Matrix for Men

	Age	SES	YM	NS	FA	S	ASS	SSS	MF	RF	PA	A	R	C	H	LS	MS	SO
Age																		
SES	.12																	
YM	.48**	.06																
NS	-.14	-.11	-.01															
FA	.20*	-.20*	.15	-.10														
S	.04	-.07	-.02	-.08	.27**													
ASS	.13	.06	.24**	.34**	.09	-.07												
SSS	.04	-.02	.11	.08	.08	.11	.21*											
MF	.09	.02	-.00	-.04	.15	.11	.25**	.18*										
RF	.12	.18*	.11	.27**	-.34**	-.22**	.10	.03	-.06									
PA	.15	.16*	.14	.13	-.19*	-.03	-.05	.11	-.06	.49**								
A	.00	.06	-.09	.17*	-.13	-.11	.16	.02	.18*	.48**	.35**							
R	.05	.07	-.01	.28**	-.15	-.21*	.19*	-.01	.08	.49**	.30**	.75**						
C	-.16	-.05	.00	-.07	-.05	.15	-.05	-.11	-.01	-.39**	-.40**	-.70**	-.54**					
H	-.00	.09	.05	.20*	-.53**	-.40**	.01	-.04	-.11	.48**	.29**	.28**	.34**	-.20*				
LS	.03	.23**	.12	.34**	-.40**	-.26**	.20*	.01	-.07	.73**	.48**	.46**	.51**	-.34**	.56**			
MS	.11	.08	.02	.21*	-.03	-.18*	.13	.08	.00	.43**	.35**	.74**	.68**	-.71**	.26**	.41**		
SO	-.15	-.03	-.21*	.31**	-.30**	-.04	.01	-.00	.02	.30**	.12	.23*	.13	-.14	.27**	.26**	.09	

* P < .05 ** P < .01

Nomenclature

Extraneous variables:

- Age = Age in years
- SES = Socio economic status
- YM = Number of years married
- NS = Social network size
- FA = Functional ability
- S = Level of stress
- SO = Source

Independent variables:

- ASS = Acquiring social support
- SSS = Seeking spiritual support
- MF = Mobilizing the family to acquire and accept help
- RF = Reframing
- PA = Passive appraisal
- A = Availability of conjugal support
- R = Reciprocity
- C = Conflict

Dependent variables:

- H = Self-assessed health
- LS = Life satisfaction
- MS = Marital satisfaction

Variable Correlation Matrix for Women

	Age	SES	YM	NS	FA	S	ASS	SSS	MF	RF	PA	A	R	C	H	LS	MS	SO
Age																		
SES	.09																	
YM	.54**	.06																
NS	-.13	.10	-.08															
FA	.36**	-.14	.19*	-.21*														
S	.02	-.06	.00	-.04	.17*													
ASS	-.11	.00	-.00	.07	-.09	.00												
SSS	.14	.02	.18*	.16	-.04	.05	.18*											
MF	-.13	-.15	-.11	.04	.00	.22**	.35**	.27**										
RF	-.00	.24**	.00	.19*	-.22**	-.17*	-.20*	-.00	-.20*									
PA	.01	.15	-.07	.20*	.01	-.07	-.13	-.03	-.05	.30**								
A	.00	.24**	-.00	.17*	-.03	-.13	-.10	.10	-.15	.66**	.11							
R	-.00	.17*	-.06	.26**	-.13	-.03	.06	.16	-.06	.60**	.15	.75**						
C	-.07	-.15	-.11	-.13	-.14	.15	.25**	.13	.21*	-.44**	-.25**	-.74**	-.53**					
H	-.01	.23**	.07	.07	-.43**	-.23**	-.05	.11	-.04	.50**	.22**	.30**	.32**	-.21*				
LS	-.06	.22**	-.00	.32**	-.34**	-.22**	-.03	.16	-.08	.71**	.30**	.55**	.62**	-.36**	.53**			
MS	-.03	.16	-.05	.23**	-.04	-.13	-.06	.15	-.09	.64**	.21*	.77**	.74**	-.62**	.36**	.62**		
SO	-.15	-.07	-.19*	.30**	-.34**	-.03	.05	.11	.18	.12	.00	.06	.11	.00	.15	.17*	.12	

* P < .05 ** P < .01

Nomenclature

Extraneous variables:

- Age = Age in years
- SES = Socio economic status
- YM = Number of years married
- NS = Social network size
- FA = Functional ability
- S = Level of stress
- SO = Source

Independent variables:

- ASS = Acquiring social support
- SSS = Seeking spiritual support
- MF = Mobilizing the family to acquire and accept help
- RF = Reframing
- PA = Passive appraisal
- A = Availability of conjugal support
- R = Reciprocity
- C = Conflict

Dependent variables:

- H = Self-assessed health
- LS = Life satisfaction
- MS = Marital satisfaction