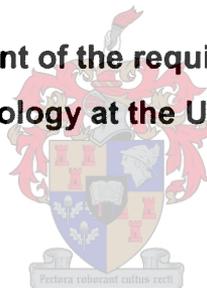


STRESS AND COPING STRATEGIES IN RECENTLY WIDOWED RURAL BLACK WOMEN

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**Thesis submitted in partial fulfilment of the requirements for the degree of Master of
Artium in Clinical Psychology at the University of Stellenbosch**



Supervisor: Dr. J.J. Spangenberg

December 2002

DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and has not previously, in its entirety or in part, been submitted at any university for a degree.

Ncebazakhe Z. Somhlaba

ABSTRACT

The relationship between stress and coping strategies in bereavement was examined in 70 recently widowed rural black women (mean age 36.53 years). Correlations were sought between coping strategies (as measured by the Coping Strategy Indicator) and anxiety (as measured by the S-scale of the State-Trait Anxiety Inventory), depression (as measured by the Beck Depression Inventory), social support (as measured by the Social Support Scale) and biographical variables. Of the participants, 88.57% were at least mildly depressed, while 78.57% experienced anxiety of above average intensity. Depression scores were significantly higher for those who were unemployed than for those who had paid work. Those with an education of Standard 6 or below made significantly more use of social support-seeking strategies than those with high school and tertiary education. Those whose husbands had died suddenly made more use of problem-solving strategies, while those whose husbands had died of chronic illness made more use of social support-seeking coping strategies. Significant positive correlations were found between an avoidant coping strategy and both depression and anxiety. A significant positive correlation was found between a social support-seeking coping strategy and perceived social support. Significant negative correlations were found between both problem-solving and social support-seeking coping strategies and anxiety as well as depression scores. An avoidant coping strategy emerged as a significant positive predictor of both anxiety and depression, while problem-solving and social support-seeking coping strategies emerged as significant negative predictors of depression. A problem-solving coping strategy alone emerged as a significant negative predictor of anxiety. These findings point to the need for interventions aimed at more effective use of problem-solving and social support-seeking coping strategies, rather than avoidance, if the widowed are to effectively deal with their conjugal loss. Another implication of these findings is the importance of helping those who are undergoing bereavement to continuously re-define their social support structures for continued sustenance of social and emotional support.

OPSOMMING

Die verband tussen stres en hanteringstrategieë is in 'n groep van 70 landelike swart vrouens (gemiddelde ouderdom 36.53 jaar) wat hul eggenote onlangs aan die dood afgestaan het, ondersoek. Korrelasies tussen hanteringstrategieë (gemeet deur die *Coping Strategy Indicator*) en angs (gemeet deur die S-skaal van die *State-Trait Anxiety Inventory*), depressie (gemeet deur die *Beck Depression Inventory*), sosiale ondersteuning (gemeet deur die *Social Support Scale*) en biografiese veranderlikes is ondersoek. Van die deelnemers was 88.57% minstens tot 'n ligte mate depressief, terwyl 78.57% bogemiddelde angsvlakke ervaar het. Depressietellings van werklose vroue was hoër as van diegene met 'n gesalarieerde werk. Diegene met Standaard 6 opleiding of laer het beduidend meer gebruik gemaak van sosiale ondersteuning-soekende strategieë as diegene met hoërskool en tersiêre opleiding. Diegene wie se eggenote skielik afgesterf het, het meer gebruik gemaak van probleemoplossende hanteringstrategieë terwyl diegene wie se eggenote afgesterf het as gevolg van 'n chroniese siekte, meer gebruik gemaak het van sosiale ondersteuning-soekende hanteringstrategieë. Beduidende positiewe korrelasies is aangetref tussen 'n vermydende hanteringstrategie en beide depressie en angs. 'n Beduidende positiewe korrelasie is aangetref tussen 'n sosiale ondersteuning-soekende hanteringstrategie en waargenome sosiale ondersteuning. Beduidende negatiewe korrelasies is aangetref tussen beide probleem-oplossende en sosiale ondersteuning-soekende hanteringstrategieë en angs sowel as depressie. 'n Vermydende hanteringstrategie was 'n beduidende positiewe voorspeller van beide angs en depressie, terwyl probleem-oplossende en sosiale ondersteuning-soekende hanteringstrategieë beduidende negatiewe voorspellers was van depressie. 'n Probleemoplossende hanteringstrategie was 'n beduidende negatiewe voorspellers van angs. Hierdie bevinding dui op die noodsaaklikheid van intervensies wat gemik is op die meer effektiewe gebruik van probleem-oplossende en sosiale ondersteuning-soekende hanteringstrategieë, eerder as vermyding, vir die weduwee om die afsterwe van haar eggenoot effektief te kan hanteer. Nog 'n implikasie van die bevindinge is die belangrikheid daarvan om diegene wat rou te help om voortdurend hul sosiale ondersteuningstrukture te herdefinieer vir voortdurende onderhouding van sosiale en emosionele ondersteuning.

The article format of this thesis is in
accordance with the requirements of
Department of Psychology

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- Finally, all my friends and acquaintances whose support I continue to relish.

DEDICATION

This one is for my mother, **MaHlangabezo** - herself thirteen months widowed when the study was initiated in March 2000, and all those women out there who continue to bear the strain of conjugal loss.

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ABSTRACT

The relationship between stress and coping strategies in bereavement was examined in 70 recently widowed rural black women (mean age 36.53 years). Correlations were sought between coping strategies (as measured by the Coping Strategy Indicator) and anxiety (as measured by the S-scale of the State-Trait Anxiety Inventory), depression (as measured by the Beck Depression Inventory), social support (as measured by the Social Support Scale) and biographical variables. Of the participants, 88.57% were at least mildly depressed, and 78.57% experienced anxiety of above average intensity. Depression scores were significantly higher for those who were unemployed than for those who had paid work. Those with an education of Standard 6 or below made significantly more use of social support-seeking strategies than those with high school and tertiary education. Those whose husbands had died suddenly made more use of problem-solving strategies, while those whose husbands had died of chronic illness made more use of social support-seeking coping strategies. Significant positive correlations were found between an avoidant coping strategy and both depression and anxiety. A significant positive correlation was found between a social support-seeking coping strategy and perceived social support. Significant negative correlations were found between both problem-solving and social support-seeking coping strategies and anxiety as well as depression scores. An avoidant coping strategy emerged as a significant positive predictor of both anxiety and depression, while problem-solving and social support-seeking coping strategies emerged as significant negative predictors of depression. A problem-solving coping strategy alone emerged as a significant negative predictor of anxiety. These findings point to the need for interventions aimed at more effective use of problem-solving and social support-seeking coping strategies, rather than avoidance, if the widowed are to effectively deal with their conjugal loss. Another implication of these findings is the importance of helping those who are undergoing bereavement to continuously re-define their social support structures for continued sustenance of social and emotional support.

STRESS AND COPING STRATEGIES IN RECENTLY WIDOWED RURAL BLACK WOMEN

Bereavement through the loss of a spouse is one of the few areas in contemporary psychology that have received far more attention from bereavement researchers than any other in the areas of death and dying (Lund, 1989; Stroebe, Stroebe, & Hasson, 1993). As such, the focal point has been on the impact that both the loss of a spouse and the entire bereavement process have on the psychological well-being of the bereaved spouse (Gallagher-Thompson, Futterman, Farberow, Thompson, & Peterson, 1993; Lund, Caserta, & Dimond, 1989; Thompson, Gallagher-Thompson, Futterman, Gilewski, & Peterson, 1991). Bereavement through the loss of a spouse is a life event that may be too stress-inducing to the surviving spouse to effectively cope and deal with the loss and adapt to the new situation. Hodgkinson (1984) is of the opinion that the process of bereavement constitutes “a major hazard to the health of the surviving spouse or relative” (p.22). A somewhat similar view is espoused by Botha and Pieters (1987), who maintain that “all people exposed to significant loss experience varying degrees of grief” (p.3). Some researchers (for example, Biondi & Picardi, 1996) have found that bereavement impacts on the subjective well-being of the bereaved so intensely that it could be viewed as a risk factor for the development of major psychiatric illnesses, particularly if the loss is abrupt and unforeseen.

As far as could be established, no studies have been done in South Africa to determine the nature of the relationship between stress and coping in the process of bereavement, let alone in the black population – a factor important enough to argue for continued research in this specific area.

Factors such as men’s direct involvement in violence, wars, and the work force – all which not only keep them away from their families, but also place them in hazardous situations – could be some of those factors that render them vulnerable to

premature death. Leaving their surviving spouses behind, it is of paramount importance to note how these bereaved women cope with the stresses associated with the death of their husbands as well as how they adapt to their new widowhood status. Generally, the research literature indicates that problem-focused, active coping styles are superior to emotion-focused, passive coping styles, including avoidance (Coetzee & Spangenberg, 2002). What researchers seem to agree on is that coping strategies play an important role in an individual's physical and psychological well-being (Endler & Parker, 1990; Miller, Brody, & Summerton, 1988).

Defining the three main concepts, namely *stress*, *coping* and *bereavement* is a prerequisite for understanding of how women deal with the death of their husbands. In accordance with Lazarus and Folkman's (1984) transactional model, **stress** refers to any circumstances that threaten or are perceived to threaten one's well-being and thereby tax one's coping abilities (Lazarus & Folkman, 1984; Sue, Sue, & Sue, 1994; Weiten, 1995). Monat and Lazarus (1991) delineate three types of stress with which individuals grapple in their day-to-day life encounters, namely *systemic* stress, *psychological* stress, and *social* stress. What is apparent from this distinction is that stress is not necessarily internally induced, but rather a phenomenon that is conceptualised as a process of interaction between the individual and his or her environment – an idea also espoused by Lazarus and Folkman (1984) in their conceptualization of stress. Accordingly, an individual tends to be in an anticipatory situation if he or she feels physically or psychologically threatened. If the initial evaluation of the event shows that it is stressful (primary cognitive appraisal), then the individual evaluates the available coping resources and options at his or her disposal in order to deal with such a stressful situation (secondary cognitive appraisal). Still pertaining to stress, Lazarus (1999) warns that stress ought not to be viewed as a

unidimensional concept but as one that involves an intimate relationship with emotion, for the two cannot be disentangled. Thus, Lazarus warns, “where there is stress there are also emotions” (p. 35), and he further argues that “we cannot sensibly treat stress and emotion as if they were separate fields without doing a great disservice to both” (Lazarus, 1999, p. 36). In fact, this is in support of the earlier view of stress as an interactive process in which both the individual and environment are directly involved (Lazarus & Folkman, 1984; Monat & Lazarus, 1991).

Like stress, **coping** has received considerable attention from different authors, with each author providing his or her own definition as to what constitutes coping with a stressful situation. In their transactional model, Lazarus and Folkman (1984) maintain that coping refers to the continuous cognitive and behavioural attempts of the individual to manage the demands of a situation he or she perceives as taxing. Similarly, they later defined coping as consisting of “cognitive and behavioural efforts [made] to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Folkman & Lazarus, 1991, p. 210). These authors distinguish between problem-focused coping and emotion-focused coping. According to them, problem-focused coping involves concerted efforts to solve the problem as a way of dealing with the situation at hand, while the focal point emotion-focused coping is the channelling of appropriate emotions associated with the stressful situation in response to stress. In a further attempt to distinguish between these two coping styles, Holahan and Moos (quoted in Coetzee & Spangenberg, 2002, p. 7) described problem-focused and emotion-focused coping, respectively, as “strategies that are active in nature and oriented toward confronting the problem; and strategies that entail an effort to reduce tension by avoiding dealing with the problem” (p. 946).

In fact, coping strategies have since been grouped according to various categories in research. Two of the most common categorisations in this regard are (1) problem-focused versus emotion-focused coping strategies, and (2) active versus passive coping strategies. A specific coping style, namely avoidance, has been categorised as an emotion-focused coping style in the first categorisation and as a passive coping style in the second categorisation (Coetzee & Spangenberg, 2002). Moreover, the passive coping style of avoidance has been associated with symptoms of psychological distress (such as depression and self-blame), an external locus of control and overall reduced quality of life (Coetzee & Spangenberg, 2002).

On the basis of Lazarus and Folkman's (1984) conceptualization of stress and coping, Amirkhan (1994) maintains that the coping responses can be subsumed under three broad categories, namely *problem-focused*, *seeking social support*, and *avoidance*. There seems to be a close correlation between these response categories and the fight-or-flight response to threat that was earlier conceptualized by Cannon (quoted in Weiten, 1995). Accordingly, the problem-solving strategy would equate with actively and directly confronting (or "fighting") the stressor, avoidance would correspond with the "flight" response, and seeking social support would represent a primitive need for human contact when overwhelmed by stressful situations (Amirkhan, 1990). There is concordance between Amirkhan's (1990, 1994) conceptualization and the view that some authors (Folkman & Lazarus, 1991; Hobfoll, 1988) generally adopt, namely that coping serves as a mediator of emotional states or responses.

Having described the concepts of stress and coping and the complex interplay thereof in individuals under duress, it is interesting to examine how women bereaved of spouses cope with such death in the entire process and duration of bereavement. As

difficult as it may be to provide a precise definition of what constitutes **bereavement** as a specific type of stressor, Hodgkinson (1984), in an attempt to provide an integrated picture of the features involved therein, has succinctly described it as

...a complex set of psychological and somatic reactions which must be worked through by the surviving spouse. This grief process may become abnormal if the process is delayed in starting, unduly prolonged, if it comes to a halt, or if certain feelings are either distorted or do not appear. (p. 22)

According to the definition outlined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (American Psychiatric Association, 1994), bereavement constitutes a reaction to the death of a loved one, and the bereaved individual presents with symptoms characteristic of a Major Depressive Episode. These symptoms include guilt feelings, thoughts of death, morbid preoccupation with worthlessness, marked psychomotor retardation, prolonged and marked functional impairment, and hallucinatory experiences – all these directly related to the deceased, in which the bereaved wishes that the deceased had not died.

Given that no single definition has been offered to date as to what differentiates normal grief from pathological grief (Middleton, Raphael, Martinek, & Misso, 1993), it is not surprising that there continues to be mounting discrepancy with regard to what constitutes the “normal” duration of the bereavement process. Apparent in these diverse points of view is an observation that Shuchter and Zisook (1993) made, namely that there has been a general increase through the years, in the expected duration of time of what would be accepted as a "normal" duration of grief.

For example, Kalu (1990) has earlier viewed bereavement as extending to a period of one year during which the widow keeps a period of confinement after the burial of her husband. In similar vein, Lindstrøm (1995) is of the opinion that one year of bereavement is sufficient for a considerable degree of grief resolution. While these

two authors share the idea of one year duration, the DSM-IV alludes to the first two months after the person's death as constituting the duration of bereavement (APA, 1994).

Viewed differently, Carnelley, Wortman and Kessler (1999) maintain that the effects of conjugal bereavement on the bereaved's subjective well-being are very substantial during the first two years following the loss and tend to decrease in the third year of widowhood. Still from a divergent viewpoint, Thompson et al. (1991) suggest that the effects of grief through spousal death may persist for at least 30 months in both widows and widowers. In fact, the latter view is analogous to Sable's (1988) earlier word of caution that bereavement may last "longer than we used to believe, and [that] it encompasses a range of feelings – from sadness and anger to fear and anxiety" (p. 553).

From these different definitions, what is apparent is that bereavement comprises a very complex process that occurs within the bereaved individual himself or herself (that is, intrapersonally), and these are largely influenced by norms and expectations that in some cultures include a humble attitude and awe towards death and dying.

As mentioned earlier, much international research has focused on bereavement through spousal death (Lund, 1989; Stroebe et al., 1993) as well as the stress such a painful process induces (Gallagher-Thompson et al., 1993; Lund et al., 1989; Thompson et al., 1991).

In South Africa, the area of stress and coping appears to have received considerable attention from some prominent social science researchers to date. The populations that have been studied with regard to how they cope with inherent stress include, among others, dentists in private practice (Möller & Spangenberg, 1996), recently detoxified alcoholics (Spangenberg & Campbell, 1999), spouses of depressed

patients (Spangenberg & Theron, 1999), managers involved in post-graduate managerial studies (Spangenberg & Orpen-Lyall, 2000), parents of children with Down Syndrome (Spangenberg & Theron, 2001) and black adolescents (Spangenberg & Henderson, 2001). However, research on coping with bereavement has been limited to studies done outside South Africa.

The death of a spouse has long been identified as one of the most stressful events an individual is likely to encounter in his or her entire lifetime (Holmes & Rahe, 1967). Wright (1993) maintains that the expression of what has been termed 'grief' "is a universal response by which people adapt to a significant loss, the loss of something which was theirs, a valued possession which had special meaning" (p. 1). These views have been recently echoed by Lindstrøm (1997) who holds that "the loss of a significant other is a stressor [that] is probably the most severe trauma a human being can go through" (p. 253). It is during this period that the bereaved individual finds himself or herself grappling with the issue of loss and tries to adapt to the new widowhood status. It is also during this period that the shift occurs when the usual presence of a loved person is replaced by his or her stressful absence (Lindstrøm, 1997).

In the last two decades, much has been written on how bereaved people cope with the loss of their loved ones. During the phase of bereavement, which some authors have viewed as a period of psychosocial transition (Levy, Martinkowski, & Derby, 1994; McCrae & Costa, 1993; Parkes, 1993), bereaved individuals have been seen as in dire need of support from their significant others. In fact, the emphasis of social support as an ameliorating factor during the process of bereavement has initially received tremendous support in bereavement literature (Gallagher-Thompson et al., 1993; Stroebe & Stroebe, 1993; Stylianos & Vachon, 1993).

The idea that social support is critical for the bereaved to go through and cope with the phase of bereavement, dates back to the late 1980s when Duran, Turner and Lund (1989) viewed social support as a buffering mechanism against stressful events. According to these authors, this buffering effect occurs at two levels; firstly, between a stressful event and stress reaction, thereby lessening a stress appraisal response by allowing the person at risk to perceive that significant others will provide resources necessary for coping with the stressful event. These authors' view was that it is through contact and emotional support that the bereaved would be better able to deal with the bereavement-induced stress. At the second level, social support may intervene between the experience of stress and the possible pathological outcome, hence "an otherwise stressful situation may be relabelled to be minimally stressful due to anticipated support from others" (Duran et al., 1989, p. 70).

Despite the generally held opinion that social support is crucial for the bereaved to cope with bereavement, some authors (for example, Wellman & Hall, 1986) have gone as far as to distinguish between what they term *social networks* and *social support*. These authors hold that while members of a social network are not necessarily supportive, the network may mediate the availability and provision of social support. Similarly, Schuster and Butler (1989) differentiate between *affective (emotional)* support and *instrumental (task-oriented)* support. Emotional support is concerned primarily with availability of the support figure to be confided in, talked to when upset, nervous, or depressed, while instrumental support is concerned with more mundane activities, such as helping with finances, chores, shopping, errands and caring for the bereaved when ill. The sentiment these authors ostensibly share from these distinctions is that it is the provision of emotional support, rather than instrumental support, that is critical for the bereaved to go through grief and reach a

positive outcome. Lund (1989) is also of the opinion that social support is only *moderately* helpful to adjustment of many bereaved people. As succinctly put,

Merely having a social convoy is not enough [for the bereaved to deal with their grief], since the convoy might not be a supportive convoy... It is probably more important to know what support networks do rather than to simply know about their existence and their structural characteristics. (Lund, 1989, p. 223)

Related to the above, Stroebe, Stroebe, Abakoumkin and Schut (1996) are of the opinion that social support is able to aid only with the social, and not the emotional, loneliness of the bereaved person. As they put it, "losing a partner means losing a major attachment figure, and social support from family and friends cannot compensate for this effect" (Stroebe et al., 1996, p. 1248).

A somewhat controversial view seems to be the one espoused by Kalu (1990) who highlights the stresses embedded in widowhood, which include extended visits by relatives after the death of the husband. These relatives, while they may be assisting with the household chores and funeral preparations, may be excessively demanding and interfering – an exacerbating factor in the widow's stress levels.

Despite the debates and reservations expressed surrounding the role that support from significant others plays in the process of bereavement, the fact remains that social support seems prominent in bereavement literature. Siegel and Kuykendall (1990) also emphasized the role of social support during bereavement. In their study, they compared the psychological resilience of widows and widowers who belonged to community organisations, like the church, to those who did not belong to the church. The results revealed that membership of a church had a far more mediating effect on loss-related stress than non-membership, since the depression arising out of such loss was moderated by the social ties formed by membership of the church. As revealed by their study, belonging to a church served as a coping mechanism in the event of

loss through death, as the church offered an opportunity for a shared experience (Siegel & Kuykendall, 1990).

In fact, what has become apparent from an American study (Frantz, Trolley & Johll, 1996) is that religious affiliation has a mediating effect during the process of bereavement. These authors maintain that religion can be a source of solace for the bereaved; that is,

... a means of finding answers to seemingly [inexplicable] natural events, a source of comfort, and a guideline for human behaviour... a sense of strength for the bereaved, [in which they] ascribe meaning to the loss, and a means to resolve the ambivalence over death as a welcome visitor or a relentless intruder. (Frantz et al., 1996, pp. 151-152)

Religion thus serves to boost the morale of the bereaved person, as religious participation tends to increase his or her self-esteem, an idea earlier espoused by Sherkat and Reed (1992).

While Lund (1989) had earlier cast doubt on the idea that religion has any measurable effects on bereavement, Lindstrøm (1999) also recently expressed reservations about the role of religious faith to this end. Lindstrøm cautions that while religious faith may be a coping mechanism during bereavement - that is, promising a reunion with the dead in an after-life - such a belief of a reunion, she warns, can be a "double-edged sword" in the sense that while it comforts some, it can also lead others into death wishes and total rejection of all that could be enjoyed in this life.

A different line of thought has recently emerged with Aber (1992), who maintains that having a paid work has a mediating effect in dealing with the death of a spouse. As the author puts it, "having a paid work role identity, in addition to a spousal identity, may help mitigate the impact of the stressful life event of a husband's death" (p. 95). To this end, Aber believes that having a paid work is generally attributable to an increase in self-respect regarding the bereaved's personal potential following

spousal death, which allows her to interpret the hardships and stresses embedded therein as fairly manageable. Concerning this idea, two studies could be traced in the research literature (Lindstrøm, 1999; McCallum, Piper & Morin, 1993) that supported the idea of a paid work having ameliorating effects on bereavement. For example, Lindstrøm (1999) holds that widows benefit from having a paid job as it provides a daily and weekly rhythm of activities, social resources, and a "divertimento" from sad thoughts and emotions. What all the above authors generally do not dispute is that the paid work they refer to needs to be both financially and emotionally rewarding for it to have a positive effect on loss-related stress.

Still from a different perspective, Nolen-Hoeksema, Parker and Larson (1994) have pioneered the concept of 'ruminative coping' with bereavement. These authors regard rumination as an attempt in which the bereaved tries to cope by passively focusing on his or her negative emotions following loss through death. The authors warn, however, that this form of coping is maladaptive since it prolongs distress, as the person who ruminates tends to engage in pessimistic thinking that perpetuates the very distress the loss generates.

It has been acknowledged that the majority of the bereaved manage to adjust to their traumatic experience of loss without seeking professional help (Stroebe & Stroebe, 1993). However, what is of particular interest is that while coping with bereavement is viewed as occurring intra-individually, with the bereaved person making a concerted effort to deal with the distress inherent therein, two studies of note (Beem et al., 1999; Schut, Stroebe, van den Bout, & de Keisjer, 1997) have alluded to therapy-aided coping with the loss. For example, Schut et al. (1997) compared gender differences in the efficacy of two counselling programmes: the problem-focused counselling and emotion-focused counselling. According to Lazarus

and Folkman's (1984) concepts of problem-focused coping and emotion-focused coping, which were discussed earlier, problem-focused coping involves the efforts to solve the problem as a way of dealing with the stressful situation, while in emotion-focused coping the individual copes through emotionally processing the traumatic experience.

In their study, Schut et al. (1997) found that men fared well with emotion-focused counselling while women responded well with problem-focused counselling. These findings were contrary to the widely held view that men generally utilise more problem-focused coping while women make more use of emotion-focused coping. Schut et al. maintain that this finding can be explained by considering that when the usual coping style (problem-solving for men, and emotion-focused for women) has not worked effectively, switching from one coping strategy to the other can be expected.

Gender differences in bereavement have been investigated in a limited number of studies. Gallagher, Lovett, Hanley-Dunn and Thompson (1989) have found that men tend to suppress their emotional responses in favour of action-oriented behaviours, while women tend to use more cognitively oriented coping strategies. Though much research has not been done in support of this finding, Frantz et al. (1996) also allude to these gender differences when they maintain that men generally have difficulty asking for support with the result that people may not realize that support is needed, or that the perception may arise that men do not want help. Some men therefore seem to be very much alone in coping with the loss of bereavement.

Within-gender variations concerning the expression of bereavement have also been studied. However, in this regard only one study of note (Lindstrøm, 1999) could be traced in the research literature. In her study, the researcher investigated the

differences in coping with bereavement in relation to different feminine gender roles. To this effect, comparisons were made between *traditional* gender role widows - that is, those who had no paid work at the time of the study, and had not had paid work during most of their married years, and *modern* gender role widows, that is, those who had paid work at the time of the study, had had paid work during a considerable portion of their married years, or were retired from such work. As revealed in other studies (for example, Aber, 1992; McCallum, Piper & Morin, 1993), those who were directly involved in generating an income were found to be better copers when compared to those who subscribed to the traditional feminine gender roles of not working outside the home. In fact, the traditional gender role widows are believed to bear an extra risk of developing a strong sense of helplessness, and of generally giving up control over their lives (Lindstrøm, 1999).

The nature of the spouse's death has also been found to be a strong determinant of the nature of the expression of grief and bereavement. For example, in an earlier study (Gass, 1989), comparisons were made between a group of widowers whose spouses had died suddenly, and those whose spouses had died from a chronic illness. The results revealed that widowers whose spouses had died suddenly tended to use more problem-focused coping and more wishful thinking, self-blame, and overall emotion-focused coping strategies than those whose spouses had died from a chronic illness. Two explanations have been provided for this different bereavement pattern: Firstly, the forewarning of spousal death, which allows for potential anticipatory grieving, has been found to have a salutary effect on the adjustment of the widowed, while the sudden death of a loved one may contribute to more physical and mental distress in the bereaved and perhaps more grief reactions. A second, and related, factor is that anticipatory grief possesses adaptational value for the bereaved in the sense that the

individual gets the opportunity to start working through grief reactions, to prepare for necessary adjustments, and to conciliate for the wrongs that may have been done to the ill spouse through providing the spouse with special care and attention she might need (Gass, 1989).

Yet another recent finding of coping with bereavement has emerged with Field, Nichols, Holen and Horowitz's (1999) notion of "continuing attachment". According to Field et al., the bereaved tries to cope with the death of a loved one by making use of the deceased's possessions, which she believes would provide comfort and maintain a sense of connection with the deceased. As succinctly put, "the possessions therefore take on a symbolism in providing the bereaved with a sense of continued contact with the deceased" (Field et al., 1999, p. 212). The authors maintain that although continuing attachment provides "continuity in the context of loss" (p. 213), it is doubtful if it provides any long-term adaptation to such loss as the excessive reliance on the possessions of the deceased at six months post-loss tends to have maladaptive consequences. As an alternative, they suggest that a monologue role-play, a therapy-aided form of grieving that involves gaining comfort through fond memories, images or dreams of the deceased, be used, as it is a powerful intervention in highlighting the reality of death. Related to the above, is the idea also espoused by Lindstrøm (1999) who cautions that retaining all the deceased husband's belongings may be viewed as expressions of a denial of the husband's death, and should be classified as an avoidance-focused coping strategy.

From the review of the different studies discussed above, it is apparent that although authors do not reach consensus as to how people cope with the loss of their loved ones, there seems to be a variety of coping mechanisms people utilize in the event of loss – depending on the personal and situational variables as well as the

coping resources the bereaved have at their disposal. Of significance is that some studies seem to highlight the importance of therapy-aided coping with bereavement, while others stress the within-gender variations, and still others emphasize the nature of the spouse's death as determining the expression of bereavement.

As there has not been a single study done in South Africa to investigate the nature of the relationship between stress and coping with bereavement, research into the experience of stress and various ways of coping with conjugal loss among rural black South African women is warranted. Such a study is even more important because the psychological needs of black South African women have received little research attention up to now. From the study of Spangenberg and Pieterse (1995), there seems to be an increasing interest in research on black South African women as well as what inherent stress levels they are confronted with on a daily basis. It is hoped that the present study will stimulate continuing attention to a broader area of how blacks in South Africa cope with their stressful life events.

The results of the study will help in understanding what black South African women perceive as stressful during their new widowhood period, and which coping mechanisms they tend to use in the wake of such a stressful time of their lives. Furthermore, an in-depth understanding of how these widowed women cope with bereavement-related stressors would help to develop appropriate psychosocial interventions. Such understanding could also serve as a means of identifying and supporting individuals whose coping strategies lead to increased psychological, social and physical vulnerability. It is such an understanding that would assist community psychologists in the development of effective therapeutic interventions, where indicated.

The specific objectives of the present study were fourfold. Firstly, the study aimed to determine how conjugal bereavement as a specific type of stressor was experienced by the group of women recently¹ bereaved of their spouses. This was done by examining their depression and anxiety levels. Secondly, the study determined which coping strategies these women tended to use in the wake of their spouses' death. Thirdly, the study explored whether there were any correlations between specific coping strategies and these women's stress levels, as manifested in anxiety and depression. Fourthly, correlations between biographical variables and coping strategies, anxiety and depression were investigated. It is hoped that this study will shed some light on how people bereaved of their loved ones in South Africa generally cope with such a traumatic experience.

METHOD

Participants

The sample consisted of 70 Xhosa-speaking², recently widowed, rural black women from the geographical area of Bizana district, Eastern Cape Province of the Republic of South Africa. Only those women whose husbands had died within the past 12 months were included in the study, considering that they would be in the mourning phase for a period of one year after the burial of their husbands.

¹ Recognising that '*recently*' is more a relative than an absolute concept, and that the duration and expression of 'normal' bereavement depends entirely on the norms and values of the particular cultural group that defines it (APA, 1994), women considered as 'recently widowed' were those who were in their first year of conjugal bereavement. This is analogous to Kalu's (1990) view that the first year after the death of spouse is a critical phase of bereavement in traditional African women.

² Though the people living in this geographical area are exposed to both the Xhosa and Zulu languages, and consist of the Mpondos – a sub-group not categorised under the Xhosa proper ethnic group, they are referred to in this thesis as Xhosa speaking. This is primarily because the 'Mpondo' language, which is a Xhosa dialect, is not recognised as one of the eleven official languages of South Africa.

This is a requirement that forms part of the cultural norms and values of the society in which they live. The original sample comprised 77 widowed women from the Bizana district. However, because the participants' right to refuse participation in the study was emphasized, five participants declined participation, thus yielding a refusal rate of 6.49%. Various reasons were given for such refusal: a) "still too painful to talk about it" (n = 3); b) "just unwilling to participate" (n = 1); c) "it will not help me lessen my grief" (n = 1). In two of the participants' questionnaires there was missing information, and the decision was made to exclude these for data analysis. The sample size was thus reduced to a total of 70 participants.

The participants' age ranged from 25 to 58 years ($M = 36.53$ years, $SD = 7.24$). Twenty percent of them had a monthly family income of less than R1000; 71.4% had a monthly family income of between R1000 and R5000; while 8.6% had a monthly family income of between R5000 and R10 000. The number of people in participant's households was 3 (for 1.4%), 4 (for 10.1%), 5 (for 15.7%), 6 (for 30.0%), 7 (for 27.1%), 8 (for 11.4%), 9 (for 2.9%), and 10 (for 1.4% of participants).

Of the women who participated in the study, 7.1% had a university or technikon education, 35.7% had a college education, 44.3% had a high school education or matric, 8.6% had Standard 6 or below, while 4.3% never went to school.

Their job status ranged from being unemployed (30%), domestic worker (7.1%), secretarial job (4.3%), clerical work (5.7%), waitress (2.9%), sales clerk (1.4%), nurse (17.1%), teacher (24.3%), self-employed (1.4%), petrol attendant (2.9%), to general labourer (2.9%). At the time of data collection, the duration of the participants' bereavement ranged from 1 month to 12 months ($M = 8.04$ months, $SD = 2.79$). When their spouses died, the duration of participants' marriages ranged from 1 year to 28 years ($M = 9.90$ months, $SD = 7.01$).

The cause of husbands' deaths ranged from motor vehicle accidents (27.1%), other unspecified accidents (7.1%), murder (12.9%), heart attack (7.1%), high blood pressure (1.4%), suicide (1.4%), alcohol related death (1.4%), diabetes (5.7%), other unspecified illnesses (31.4%), to stroke (4.3%).

Measuring instruments

All four measuring instruments used in gathering the data were translated from English to Xhosa with the help of translators of the Department of African Languages at the University of Stellenbosch, who also helped with back translation to determine if the initial translation had been accurate.

- a) *A demographic questionnaire* was used to obtain data regarding participants' age, education, job status, duration of bereavement, total monthly family income, number of people in the household, duration of marriage, and husband's cause of death.
- b) *Beck Depression Inventory (BDI)* (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Beck, 1967).

The BDI is a 21-item self-report scale of a wide range of symptoms that are generally characteristic of depression, which was designed to measure the degree of the symptoms of depression (Beck et al., 1961; Beck, 1967). Accordingly, the respondents indicate the severity of their depressive symptoms on a 4-point scale, with 0 indicating the absence of the symptoms and 3 indicating a severe depressive symptom. The cut-off scores for the BDI are as follows: less than 10: not depressed; between 10 and 19: mildly depressed; between 20 and 25: moderately depressed; 26 and above: severely depressed (Beck, 1967). The BDI has been widely used in social science research and has been established as a reliable and valid tool for measuring

the severity of the depressive symptomatology both in clinical and research settings (Beck, Steer, & Garbin, 1988). Since women bereaved of their spouses are assumed to be presenting with a variety of depressive symptoms that include crying spells, depressed mood, sleep disturbances and fatigue (Clayton, 1990; Zisook, 1993; Zisook & Shuchter, 1991, 1993; Zisook, Shuchter, Sledge, Paulus, & Judd, 1994), the BDI was regarded as a suitable measuring instrument for the present study. Especially important, is the general expectation that people encountering loss do go through a period of psychological distress (Wortman & Silver, 1991). The use of the BDI was therefore indicated to measure the depressive symptoms present in the recently widowed women. Previous South African studies in which the BDI was used to measure depression as a manifestation of stress included recently detoxified alcoholics (Spangenberg & Campbell, 1999), spouses of depressed patients (Spangenberg & Theron, 1999), rural black women with postpartum depression (Spangenberg & Lacock, 2001) and parents of children with Down Syndrome (Spangenberg & Theron, 2001).

c) State-Trait Anxiety Inventory (STAI) (Spielberger, Lushene, Vagg, & Jacobs, 1983).

The STAI is a 40-item self-report scale that was designed to measure the severity of the anxiety symptoms. The S-scale of the STAI, which measures state anxiety, was used to measure the respondents' anxiety levels. In the STAI participants rate their subjective anxiety on a 4-point scale, with 0 indicating the absence of anxiety symptoms and 3 indicating a severely anxious state (Spielberger et al., 1983). The STAI has shown good test-retest reliability, internal consistency, and criterion validity (Spielberger et al., 1983). Moreover, from the previous studies on stress and coping done in South Africa (for example, Möller & Spangenberg, 1995; Spangenberg &

Campbell, 1999; Spangenberg & Theron, 1999, 2001), which made use of the STAI to measure the degree of anxiety as a manifestation of stress, the STAI has proved to be a reliable measuring instrument for anxiety in South African research populations. Since the loss of a husband has long been thought to be an event that is both fear-inducing and anxiety-provoking in many bereaved spouses throughout the first three years of their bereavement (Lindström, 1995; Sable, 1988, 1991), the STAI was indicated as a suitable measure of the degree of the anxiety symptoms among the respondents.

d) The Coping Strategy Indicator (CSI) (Amirkhan, 1990, 1994).

The CSI is a 33-item self-report scale that measures the extent to which respondents make use of the three basic coping styles, namely problem-solving, avoidance and seeking social support (Amirkhan, 1990). The CSI clearly distinguishes itself from previous coping inventories, which identify problem-focused coping and emotion-focused coping as the only coping modes human beings have at their disposal (Lazarus & Folkman, 1984). In comparison, the CSI includes avoidance as a negative form of an emotion-focused coping style, on the one hand, while it specifically identifies the use of social support, which can be classified as both an emotion-focused and problem-focused coping strategy. Amirkhan (1990, 1994) thus includes avoidance and seeking social support as additional coping modes to the problem-solving coping strategy earlier identified. The CSI has demonstrated high internal consistency coefficients of .92, .89 and .83 for problem-solving, seeking social support and avoidance coping strategies respectively, as well as test-retest reliability coefficients of .82 and .81 (Amirkhan, 1990, 1994). The CSI has also been extensively used in South African research settings (Wissing & Du Toit, 1994;

Spangenberg & Campbell, 1999; Spangenberg & Orpen-Lyall, 2000; Spangenberg & Theron, 1999, 2001).

d) The Social Support Scale (SSS).

Since plenty of studies from the bereavement literature (Duran et al., 1989; Gallagher-Thompson et al., 1993; Schuster & Butler, 1989; Siegel & Kuykendall, 1990; Stroebe & Stroebe, 1993; Stroebe et al., 1996; Stylianos & Vachon, 1993) emphasized the role of social support in dealing with grief, the present study sought to measure the support received from the respondents' significant others in the wake of their spouses' death. However, no standard instrument was found to be socio-culturally applicable to the specific variable under investigation. Hence, an inclusive instrument - the Social Support Scale (SSS) - was designed by the present author, in collaboration with the research supervisor and a senior research assistant in the Department of Psychology at Stellenbosch University, which permitted the variable of social support to be studied effectively. Thus, the SSS is a 17-item questionnaire that measures social support received by rural African women. Accordingly, respondents rated the extent to which they received support from their significant others on a 5-point scale - with 1 indicating "never received support" and 5 indicating "always received support". Examples of items include, among others, parents, friends and other women generally (see Appendix). The expert opinion of the researcher, research supervisor and senior research assistant, who has a Master's degree in Research Psychology, were taken as evidence of content validity of the SSS.

Procedure

The gathering of data was done with the help of five male research assistants who were approached in June 2001, and trained by the present researcher in how to go

about gathering the data. All the research assistants used Xhosa³ as their mother tongue, and could speak and write both Xhosa and English fluently. This allowed the process of data gathering to be manageable, as the assistants were able to read and understand the content of the questionnaires, which enabled them to answer the questions the respondents asked. The research assistants were remunerated for their work.

The participants were identified through the help of the local chiefs, who knew which women amongst their people had been widowed during the last year. As previously arranged by the present researcher, the chiefs made special announcements that these recently widowed women were invited to voluntarily come to the palace to be interviewed by the researchers. The right to refuse participation was emphasized in order to give an opportunity for participants to express their unwillingness, should there be any, to participate. Participants who gave informed consent were then convened to the local chiefs' 'royal' palaces⁴ in order to participate in the interviews.

The administration of the questionnaires began by rapport building, in which the research assistants attempted to establish contact with the participants before asking them questions (as indicated in the questionnaires) about their depressive and anxiety symptomatology. Asking questions relating to the respondents' biographical details first allowed respondents to honestly volunteer information that was needed. To guarantee confidentiality of the information given, all respondents were interviewed

³ Please see Footnote 2.

⁴ This was especially important, as all the research assistants were males, who would probably experience difficulty with door-to-door data gathering. In fact, most families prohibit the widow's private contact with male strangers during the period (extending to a year) of mourning. Being invited to the royal palace was less likely to be held in contempt by the widows' families, since the chiefs are the respected figures of authority who, as generally believed, uphold the society's cultural norms and values.

individually on an anonymous basis – with one research assistant interviewing one participant at a time. Each interview lasted for about 1 hour.

In cases where participants could read and write, and were prepared to complete the questionnaire themselves, this was done, although the present researcher and assistants were available for questions regarding clarity that were raised pertaining to completing the questionnaires. In these cases, completing in the questionnaires took about 30 minutes. The present researcher was available for limited times in order to monitor efficient data gathering as well as to answer questions that might arise.

Statistical analyses

The Pearson correlation coefficient was used to examine the correlations between the problem solving, social support-seeking and avoidant coping strategies, and depression and anxiety respectively. The Pearson correlations between the social support *received* and problem solving, seeking social support and avoidant coping strategies, as well as depression and anxiety, were also examined.

Stepwise multiple regression analyses were conducted to determine which of the three coping strategies functioned as key variables in predicting both anxiety and depression experienced by participants.

The relationships between the biographical variables and each of the main variables, namely depression, anxiety, problem-solving, social support-seeking and avoidant coping strategies were examined. For this purpose, two-tailed t-tests were used to compare the means for the following biographical variables, which were broken down into two categories each: educational level, job status, the mode of husband's death, and duration of bereavement. Pearson correlations were also calculated between these variables and each of the main variables (that is, depression, anxiety, problem-solving, social support-seeking, and avoidant coping strategies).

RESULTS

The prevalence of depression and anxiety

As per BDI cut-off points, the prevalence of the various categories of depressive symptomatology was as follows: within the normal range = 8 (11.43%); mildly depressed = 12 (17.44%); moderately depressed = 28 (40.0%); severely depressed = 22 (31.43%). Therefore, this means that 88.57% of the participants were at least mildly depressed and 71.43% were moderately or severely depressed.

On the STAI, a score of 35 represents the 50th percentile rank, while a score of 40 represents the 75th percentile rank (Spielberger et al., 1983). According to the participants' scores on the STAI, the anxiety levels of 55 of the participants (78.57%) were above the average anxiety level.

A significant positive correlation was found between participants' scores on depression and anxiety ($r = .82$, $p < .001$). This means that the more intense depression participants experienced, the higher were their anxiety levels and vice versa.

The prevalence of the three kinds of coping strategies

According to their scores on the CSI, it appeared that 70.0% of the participants made a high use of an avoidant coping strategy, relative to only 17.14% who made high use of a problem-solving coping strategy and 12.86% who made high use of a social support-seeking coping strategy.

Correlations between anxiety and coping strategies

The correlations between anxiety and the three types of coping strategies were investigated by means of Pearson correlation coefficients. The results yielded by the analysis are recorded in Table 1.

Table 1. Correlations between Participants' Scores on the S-scale of the STAI and Scores on the Three Coping Strategy Scales of the CSI (N = 70)

Coping strategies	r	p
Problem-solving strategy	-.813	.000***
Social support-seeking strategy	-.814	.000***
Avoidant strategy	.952	.000***

*** $p < .001$

As illustrated in Table 1, a significant positive correlation was found between scores on the S-scale of the STAI and on the avoidant coping strategy scale ($r = .952$, $p < .001$). This implies that the more the participants made use of an avoidant coping strategy, the higher were their anxiety scores and *vice versa*.

A significant negative correlation was found between scores on the S-scale of the STAI and on the problem-solving coping strategy scale ($r = -.813$, $p < .001$). This implies that the more participants made use of problem-solving strategies, the lower were their anxiety scores and *vice versa*.

In a similar vein, significant negative correlations were found between scores on the S-scale of the STAI and on the social support-seeking strategy scale ($r = -.814$, $p < .001$). This suggests that the more participants made use of social support-seeking strategy, the lower were their anxiety scores and *vice versa*.

Correlations between depression and coping strategies

The correlations between depression and the three types of coping strategies were also investigated through the use of Pearson correlation coefficients. The results yielded by the analysis are given in Table 2.

Table 2. Correlations between Subjects' Scores on the BDI and Scores on the Three Coping Strategy Scales of the CSI (N = 70).

Coping strategies	<i>r</i>	<i>p</i>
Problem-solving strategy	-.703	.000***
Social support-seeking strategy	-.746	.000***
Avoidant strategy	.776	.000***

****p* < .001

As illustrated in Table 2, a significant negative correlation was found between depression scores and scores on the problem-solving coping strategy scale ($r = -.703$, $p < .001$). This implies that the more participants made use of the problem-solving coping strategies, the lower were their depression scores and *vice versa*. A significant negative correlation was also found between depression scores and scores on the social support-seeking coping strategy scale ($r = -.746$, $p < .001$). This implies that the more participants made use of social support-seeking coping strategies, the lower were their depression scores and *vice versa*.

A significant positive correlation was found between depression scores and scores on the avoidant coping strategy scale ($r = .776, p < .001$). This suggests that the more participants made use of avoidant coping strategies, the higher were their depression scores and *vice versa*.

Prevalence of sources for social support

It appeared that participants perceived that they had *always received* social support from various social support structures in the wake of their spouses' death. Only sources of social support from whom participants reported that they always received social support in fairly high percentages (21.4% and higher) are reported here. The main sources from whom participants perceived to have *always received* social support included their own children (32.9% of the cases), parents-in-law (27.1%), sisters-in-law (45.7%), brothers-in-law (31.4%), other widowed women (32.9%), the church (21.4%), and other women generally (32.9%).

A significant negative correlation was found between social support scores and depression scores ($r = -.350, p < 0.01$). This implies that the more participants received social support from the social support figures, the lower were their depression scores and *vice versa*. The negative correlation between social support scores and anxiety scores was insignificant.

Correlations between perceived social support and coping strategies

The correlations between the social support received and the three types of coping strategies were investigated by means of Pearson correlation coefficients. The results yielded by the analysis are reported in Table 3.

Table 3. Correlations between Subjects' Scores on the Social Support Scale and Scores on the Three Coping Strategy Scales of the CSI (N = 70)

Coping strategies	r	p
Problem-solving strategy	.208	.084
Social support seeking strategy	.313	.008**
Avoidant strategy	-.183	.129

**p < .01

As illustrated in Table 3, a significant positive correlation was found between the scores on the SSS and social support-seeking coping strategy scale ($r = .313$, $p < .01$). This implies that the more participants made use of social support-seeking coping strategies, the higher the social support they perceived to have received and vice versa.

The positive correlation between the scores on the SSS and problem-solving coping strategy as well as the negative correlation between scores on the SSS and the avoidant coping strategy scores were both insignificant.

Coping strategies that functioned as key variables in predicting anxiety

A stepwise multiple regression analysis was conducted in order to determine which of the three types of coping strategies predicted anxiety. Results are recorded in Table 4.

As shown in Table 4, a problem-solving coping strategy emerged as a significant negative predictor of anxiety ($p < .05$). This points to the direction of causality in the negative correlation between scores on the problem-solving coping strategy scale and

anxiety, which implies that the use of a problem-solving coping strategy played a predictive role in the lessening of anxiety levels.

Table 4. Multiple Regression of Anxiety on the three Subscales of the CSI (N = 70)

Predictor	Coefficient	<u>SD</u>	<u>t</u> -ratio	<u>p</u>
Constant	44.083	6.312	1.349	.001
Problem-solving strategy	-.783*	.372	-1.675	.046*
Social support-seeking strategy	-.019	.353	-.106	.916
Avoidant strategy	1.349**	.051	4.879	.002**

F = 23.804

R squared = 26.0%

*p < .05

**p < .01

An avoidant coping strategy was found to be a significant positive predictor of anxiety ($p < .01$). This indicates the direction of causality in the positive correlation between scores on the avoidant coping strategy scale and anxiety, and implies that the use of an avoidant coping strategy played a predictive role in the experience of heightened anxiety levels.

Coping strategies that served as key variables in predicting depression

A stepwise multiple regression analysis was performed in order to determine which of the three coping strategies were predictors of depression. Analyses of results are recorded in Table 5.

Table 5. Multiple Regression of Depression on the Three Subscales of the CSI (N = 70)

Predictor	Coefficient	<u>SD</u>	<u>t</u> -ratio	<u>p</u>
Constant	41.302	10.411	3.967	.000***
Problem-solving strategy	-.559	-.425	-3.576	.001**
Social support-seeking strategy	-.594	-.511	-4.183	.000***
Avoidant strategy	.693	.498	4.063	.000***

F = 51.919

R squared = 60.3%**p < .01***p < .001

As illustrated in Table 5, a problem-solving coping strategy emerged as a significant negative predictor of depression, ($p < .01$). This implies that the use of a problem-solving coping strategy played a predictive role in the reduction of depressive symptoms. By the same token, a social support-seeking coping strategy was found to be a significant negative predictor of depression ($p < .001$), which suggests that the use of a social support-seeking coping strategy played a predictive role in the experience of less depressive symptoms.

An avoidant coping strategy was found to be a significant positive predictor of depression ($p < .001$). This indicates the direction of causality in the positive correlation between scores on the avoidant coping strategy scale and depression scale, namely that the use of an avoidant coping strategy played a predictive role in the heightened experience of depressive symptomatology.

Differences between biographical variables regarding anxiety, depression and coping strategies

Depression scores were significantly higher in the unemployed participants ($\underline{M} = 28.67$) than in those who were employed ($\underline{M} = 17.31$), $t(68) = 5.97$, $p < .001$. Anxiety scores of participants with Standard 6 and below or with no education (hereafter to be referred to as the *less educated*) ($\underline{M} = 31.89$) was found to be significantly higher than of those with high school and tertiary education (hereafter to be referred to as the *more educated*) ($\underline{M} = 15.44$), $t(68) = 1.98$, $p < .001$. Anxiety scores of participants whose spouses had died of natural causes (hereafter to be referred to as the *natural death group*) was found to be significantly higher ($\underline{M} = 40.67$) than those whose spouses had died suddenly (hereafter to be referred to as the *sudden death group*) ($\underline{M} = 16.32$), $t(68) = -2.32$, $p < .001$. No significant differences emerged for other biographical variables on scores of depression and anxiety.

There were significant differences between the more educated and less educated participants pertaining to the use of a social support-seeking coping strategy. The less educated participants ($\underline{M} = 20.44$) scored significantly higher on social support seeking than the more educated participants ($\underline{M} = 9.11$), $t(68) = 2.57$, $p < .001$.

Significant positive correlations were found between age and social support-seeking coping strategy scores ($r = .303$, $p < .05$), which implies that the older the women, the more they made use of a social support-seeking coping strategy. Significant positive correlations were also found between months after spousal death (that is, months post-loss) and social support-seeking coping strategy ($r = .251$, $p < .05$). This implies that the longer the period of bereavement was, the more the participants made use of a social support-seeking coping strategy. Significant negative correlations were found between duration of bereavement (months post-loss) and an

avoidant coping strategy ($r = -.247, p < .05$). The above correlation implies that the shorter the period of bereavement, the more the participants made use of an avoidant coping strategy.

Significant differences were found between the sudden death group and the natural death group with regard to the use of problem-solving coping and social support-seeking coping strategies. While the sudden death group ($M = 21.38$) scored significantly higher on the problem-solving coping strategy than the natural death group ($M = 10.86$), $t(68) = 3.44, p < .001$, the natural death group ($M = 19.36$) scored significantly higher on the social support-seeking strategy than the sudden death group ($M = 9.88$), $t(68) = -5.05, p < .001$. No other significant differences or correlations were found between coping strategies and biographical variables.

DISCUSSION

Depression

The findings of the present study revealed that an alarming 88.57% of the participants presented with at least mild depression and 71.43% with moderate to severe depression. This is a pattern that is consistent with previous research in this specific field (Carnelley, Wortman & Kessler, 1999; Clayton, 1990; Thompson et al., 1991; Zisook, 1993; Zisook & Shuchter, 1991, 1993; Zisook, Shuchter, Sledge, Paulus, & Judd, 1994), who all found that people encountering the loss of a spouse through death experienced heightened levels of depressive symptomatology.

Two American studies of note have been conducted to determine the prevalence of depressive phenomena in widows following the death of their spouse. For example, Zisook et al. (1994) found that the depressive symptoms in women 13 months post-loss ranged from mild depression (for 26% of participants), moderate (13 %) to severe (4 %). On the other hand, Carnelley et al. (1999) found 10.5% of participants in their

study to be presenting with depressive phenomena that warranted a clinical diagnosis of a major depression at one year post-loss.

The reason for the apparent discrepancy between the findings of these two American studies and the findings of the extremely high prevalence of depression in the present study is not clear-cut, and merits further investigation. A possible explanation is that since black women in South Africa have been found to be experiencing a lot of psychological distress emanating from numerous psychosocial stressors such as undesirable life changes, recurring life events as well as continuous life events (Spangenberg & Pieterse, 1995), the death of a husband could have been an additional stressor to the ones already experienced. Moreover, Spangenberg and Lacock (2001) recently found the incidence of postpartum depression in rural black South African women to be alarmingly high (64.9%). For the postpartum depressed women in Spangenberg and Lacock's study, numerous psychosocial factors such as being married, experiencing relationship difficulties with partner or husband, having had an unplanned pregnancy, financial problems, and dissatisfaction with the social support system, were all cited as having a detrimental effect on their psychological well-being.

These previous findings therefore support the idea that the participants in the present study may have been experiencing ongoing psychosocial stressors in addition to the loss of a spouse. Since the prevalence of depressive symptomatology is very high, the results of the present study point to the necessity of psychological help for the conjugally bereaved women in the rural areas to cope with the death of their husbands. It is therefore imperative that psychotherapeutic support systems should be put in place for black people in rural areas.

Anxiety

The results of the S-scale of the STAI showed that 78.57% of the participants experienced anxiety at above average levels. This is consistent with previous research findings (Lindstrøm, 1995; Sable, 1988, 1991), and confirmed the high prevalence of anxiety found in conjugally bereaved spouses. For example, Sable (1988) found that 52% of the respondents in her study reported experiencing worry, panic and fear after the husband's death.

Once again, due to the high prevalence of anxiety symptoms reported by participants in the present study, bereavement treatment programmes in rural areas are warranted in order to help recently bereaved women cope with conjugal loss.

Relationship between depression and anxiety

Significant positive correlations were found between anxiety and depression. In fact, the finding that participants in the present study presented with high incidences of both depression and anxiety was not surprising, given that the loss of a spouse has long been found to be one of the most severe traumas a human being is likely to experience in his or her lifetime (Holmes & Rahe, 1967; Lindstrøm, 1997). Moreover, the universality of the grief reactions after the loss of a significant other, in which the bereaved tries to adapt to such a loss, has also been noted by some authors (for example, Botha & Pieters, 1987; Wright, 1993). It must also be kept in mind that both anxiety and depression are inherent aspects of psychological distress, and measures of both anxiety and depression have often been used in research as indications of the emotional manifestations of stress (Spangenberg & Theron, 2001). In fact, a clinical overlap has long been found to exist between anxiety and depression (Clark, 1989; Dobson, 1985; Lazarus, 1993; Lovibond & Lovibond, 1995; Stavrakaki & Vargo, 1986).

Relationship between depression and coping strategies

A significant positive correlation was found between participants' scores on the BDI and their scores on the avoidant coping strategy scale. Consequently, the more participants used the avoidant coping strategy, the more they experienced depressive symptoms and vice versa. Moreover, regression analysis indicated that avoidance played a predictive role in depression. This is in line with previous international as well as South African findings in which avoidant coping strategies were positively associated with depression (for example, Spangenberg & Campbell, 1999; Spangenberg & Theron, 1999, 2001). The present finding thus again highlights the detrimental effect of avoidance on psychological well-being - also in recently bereaved women.

A significant negative correlation was found between the BDI scores and scores on the problem-solving coping strategy scale, which suggests that the more participants utilised a problem-solving coping strategy, the lower were their depression scores and vice versa. In addition, regression analysis indicated the predictive role of problem-solving strategies in a decrease in depression. Previous international and South African studies have also highlighted the negative relationship between problem-solving coping strategies and depressive symptoms (for example, Spangenberg & Campbell, 1999; Spangenberg & Theron, 1999). It seems clear, therefore, that problem-solving coping skills should be enhanced to decrease depression in recently bereaved women.

Scores on the social support-seeking coping strategy scale also proved to be negatively correlated to the depression scores, implying that the more participants made use of social support-seeking coping strategies, the lower were their depression scores and vice versa. However, no previous research was found to be consistent with

this finding. A social support-seeking coping strategy also emerged as a negative predictor of depression. This points out the direction of causality in the negative correlation found between social support-seeking coping strategy and depression, and thus implies that those participants who garnered social support from their significant others during their stressful period of spousal bereavement experienced a decrease in depressive symptoms. No previous findings in this regard were found to compare with this finding. However, when considering the socio-cultural context in which the participants reside, which is characterised by a collectivist worldview and mutually supportive interpersonal relationships, it stands to reason that, for the widowed women, reaching out for social ties served to moderate their depressive symptoms. Related to this finding, Spangenberg and Henderson (2001) found that a collectivist, supportive world-view, often termed *ubuntu*, had a buffering effect against stress among black South African adolescents. The implication this finding has for the widowed is the importance of continuously connecting with their social ties for the sustenance of both social and emotional support in times of duress - this being a way of moderating depressive symptomatology.

Relationship between anxiety and coping strategies

Significant positive correlations were found between participants' scores on the S-scale of the STAI and their scores on the avoidant coping strategy scale of the CSI. This indicates that the more participants made use of an avoidant coping strategy, the higher were their anxiety levels and *vice versa*. In addition, regression analysis demonstrated that avoidance tended to increase anxiety levels. This finding is in line with the findings in previous international as well as South African studies (for example, Spangenberg & Campbell, 1999; Spangenberg & Theron, 1999), which also found an avoidant coping strategy to be an attributable factor in increased anxiety

levels. This finding thus presents additional evidence of the negative effect of avoidance on psychological well-being.

A significant negative correlation was found between participants' scores on the S-scale of the STAI and on the problem-solving coping strategy scale, implying that the more participants made use of a problem-solving coping strategy, the less was their experience of anxiety and *vice versa*. Moreover, regression analysis indicated that a problem-solving coping strategy played a predictive role in the lessening of anxiety levels. This is consistent with two South African studies done on recently detoxified alcoholics (Spangenberg & Campbell, 1999) and on patients with systemic lupus erythematosus and rheumatoid arthritis (Venter, Spangenberg, Hugo, & Roberts, 1999), which also found similar relationships between anxiety and a problem-solving coping strategy. This finding highlights the positive value of a problem-solving coping strategy for mental health, and emphasizes that this is also applicable to recently widowed women.

A significant negative correlation was found between participants' scores on the S-scale of the STAI and the social support-seeking coping strategy scale, suggesting that the more participants made use of a social support-seeking coping strategy, the less was their experience of anxiety and *vice versa*. However, no predictive relationship was revealed by means of regression analysis. Up to now no previous study revealed a significant negative correlation between anxiety and a social support-seeking coping strategy.

In summary, it is evident that the use of both problem-solving and social support-seeking coping strategies is necessary for the reduction of recently bereaved women's depression and anxiety levels. Those participants who actively engaged in a task-oriented, practical, 'problem-solving' approach in reaction to their stressor (in this case

the stressful conjugal loss) experienced a decrease in depression and anxiety. It thus seems that the use of a problem-solving strategy of coping with spousal death serves as a buffer against depressive symptoms, and has far more enduring effects in coping with everyday life stress.

On the other hand, an avoidant coping strategy can be regarded as a maladaptive coping mode of dealing with stress as it serves to perpetuate the anxiety and depressive symptomatology, which it purports to reduce. In fact, this was also evidenced in findings of previous South African studies (for example, Spangenberg & Campbell, 1999; Spangenberg & Theron, 1999; Spangenberg & Orpen-Lyall, 2000; Spangenberg & Theron, 2001), which highlighted the ineffectiveness of avoidant coping strategy in dealing with stress.

Relationship between perceived social support and coping strategies

Also revealed by the study, were significant positive correlations between participants' scores on the Social Support Scale (SSS) and scores on the social support-seeking coping strategy, which indicates that the more participants made use of social support-seeking coping strategies, the more likely they were to perceive themselves as having received social support and vice versa. As the SSS is not a standardised measuring instrument, no previous research has been done to determine the nature of this relationship, and hence more research is needed to examine the plausibility of the hypothesised relationship between these two variables. However, numerous previous studies (Duran et al., 1989; Gallagher-Thompson et al., 1993; Schuster & Butler, 1989; Siegel & Kuykendall, 1990; Stroebe & Stroebe, 1993; Stroebe et al., 1996; Stylianos & Vachon, 1993) have stressed the critical role of social support in dealing with stress related to loss through death. In contrast, others distinguished between social support networks and social support (Lund, 1989;

Wellman & Hall, 1986), and between affective (emotional) support and instrumental (task-oriented) support (Schuster & Butler, 1989). These distinctions imply that social support can only be helpful if it meets the grieving person at an emotional, rather than social, level. Still other researchers (Stroebe et al., 1996) held that having social ties can never compensate for the loss of a loved one. Perhaps at the extreme end, Kalu (1990) warned of the potential interference and heavy demands the social networks can pose on the grieving spouse, thus worsening her stress levels.

It thus seems as if social support can mitigate depressive symptoms, but that the deep-seated anxiety attached to the loss of a husband is resistant even to the beneficial effects of social support.

Of particular interest pertaining to social support, was the finding that participants perceived their own family (that is, parents, sisters and brothers) as having been less supportive when compared to the husband's family. Contrary to the expectation that family of origin would feature as the main social support system, the majority of participants perceived that mainly their in-laws, other widowed women, their own children, the church as well as other women generally, had always provided them with necessary social support. This finding can be quite misleading if the socio-cultural context in which participants function is not taken into consideration. The most plausible explanation for the above-mentioned trend is that the patriarchal society in which they live prescribes that, once married, a woman becomes part of her husband's family, almost to the total exclusion of, and severing the ties with, her family of origin. As it stands, the only "family" that may have been available for provision of social and emotional support is in fact the woman's new family. It can be inferred, therefore, that the participants' perception of their families of origin as not always being supportive does not necessarily translate to their families' unwillingness

to offer support, but can be understood as physical and hence emotional unavailability to serve such purpose. In fact, this is a set of conditions dictated by the societal norms, values and cultural expectations of the community amongst which the present research was conducted.

Biographical factors

A significant positive relationship was found between depression and job status; the unemployed participants being more depressed than the employed ones. This finding is consistent with those of previous researchers (for example, Aber, 1992; Lindstrøm, 1999; McCallum et al., 1993), who held that paid work identity helped the bereaved divert their sad and depressed emotions towards some other practical tasks. Having no job, which is a source of income that may have eased the stress, may have contributed to high depression. However, the present findings need to be interpreted with extreme caution and therefore cannot be generalized, since the question whether the job was satisfying was not asked.

A significant positive relationship was found between anxiety levels and the level of education. The less educated participants were found to be significantly more anxious than those with high school or tertiary education. No previous study was found that could be compared with this finding. These results could suggest that the less educated, with little exposure to and knowledge about the availability of resources of support, may not have asked for help and hence found themselves helpless in their bereaved state.

A significant negative relationship was found between anxiety and the nature of the husband's death; the natural death group having higher anxiety levels than the sudden death group. This finding is inconsistent with Gass's (1989) findings that the sudden death group was worse off relative to the natural death group. The reason for

the present findings is not clear, but given that the nature of the marital relationship before the husband's death was not explored, it would be too risky to infer that this finding is true for all recently widowed women. In fact, marital relationship prior to the husband's death is a critical area to be investigated in order to determine the relationship between the grief reactions and the nature of the husband's death.

A significant positive relationship was found between the use of a social support-seeking coping strategy and level of education. The less educated made more use of social support-seeking coping strategies. There is no previous research of note pertaining to these two variables. Viewed from a socio-cultural context, these results could point to the constant availability of social support structures for the less educated (who are more likely have more extended family members to identify with in a less literate society). Support from extended family members is characteristic of interpersonal relations in the rural areas. Should this be the case, basic support group programmes, which include more educated women, are indicated, to help the bereaved cope with the death of their loved ones.

A significant negative relationship was found between an avoidant coping strategy and the duration of bereavement (months post-loss). Thus, those whose husbands had died within the past six months made more use of avoidant coping strategies. No previous study of note investigated the relationship between these two variables. However, because bereavement is understood to be progressing through different discrete phases, of which the first phase is shock and denial (Botha & Pieters, 1987; Hodgkinson, 1984), it can be inferred that it was natural for those who were recently bereaved to be still in the initial phase of denial and thus to make use of avoidant coping strategies. Should this be so, more support groups aimed at facilitating the

grief process and giving the bereaved an opportunity for a shared experience with others, are indicated.

A significant difference was found between the use of problem-solving and social support-seeking coping strategies. While the sudden death group made more use of problem-solving strategies, the natural death group made more use of social support-seeking strategies. These findings are partially consistent with Gass's (1989) findings, in which the sudden death group was found to be making more use of problem-focused coping. Similarly, Kübler-Ross (1981) maintained that when sudden death occurs survivors are mostly not prepared for that tragic event. Upon receiving the news, they "often react with great shock and numbness to the tragic news at a time when clear thinking and fast actions are mandatory" (Kübler-Ross, 1981, p. 163). She further affirmed that these survivors often become mechanically busy with a lot of things, which include making preparations for the funeral as well as attending to relatives and visitors who come to the funeral. This practical approach to dealing with essential problems may therefore last relatively longer.

In the present study, it could be that widows whose husbands died suddenly probably had more urgent and immediate problems to attend to, while those whose husbands died after a chronic illness probably had social support systems in place of which they could make use. However, once again caution needs to be taken not to make uninformed inferences with regard to how these two groups differed in expressing bereavement, without first determining the nature of the marital relationship before the spouse's death.

No other significant differences or correlations were found between coping strategies and biographical variables.

Participants' overall use of coping strategies

Approximately 70% of the participants made a high use of an avoidant coping strategies, relative to only 17.14% who made high use of problem-solving coping strategies and 12.9% who made high use of social support-seeking coping strategies. Given the high prevalence of both depression and anxiety, and that there existed significantly positive correlations between these two negative emotions and avoidant coping strategies, this breakdown of the use of coping strategies is not surprising.

The contribution of the present study

The major contribution of the present study is the finding that the prevalence of both depression and anxiety is high in recently widowed rural black women. The extremely high incidence of depression (88.57%) is especially alarming. Although 17.44% of the women were only mildly depressed and probably merely suffered from dysphoric mood, the finding that 71.43% of them were moderately or severely depressed raises severe concern. It points to the necessity for bereavement treatment programmes.

Another meaningful contribution is the finding that the use of an avoidant coping strategy, which emerged as the one mostly used by the participants, predicts increased depressive and anxiety symptomatology. The issue of whether avoidance serves as an adaptive or maladaptive strategy appears to have generated much debate in research literature to date. For example, Lazarus (1981) held that although avoidance might be helpful within a limited time frame, it might also become dysfunctional as time lapses and prevents individuals from fully negotiating the bereavement crisis. Similarly, Kübler-Ross (1989) delineated the phases of mourning, which all individuals go through upon the death of their loved one. These phases are conceptualised as ranging from initial numbness, shock and denial, proceeding to anger, bargaining and depression, through to ultimate acceptance. Kübler-Ross further maintained that a

it stands to reason that viewing avoidance coping as adaptive for these widowed rural black women, would be tantamount to denying them the privilege of being considered for the bereavement treatment programmes.

A third meaningful contribution is the finding that problem-solving and social support-seeking coping strategies predicted decreased depression and anxiety and thus served as buffers against these negative emotions. That a problem-solving coping strategy, in particular, predicts decreased depression and anxiety, confirms findings of previous studies (Spangenberg & Campbell, 1999; Spangenberg & Theron, 1999; Venter et al., 1999) about its efficacy in dealing with the stressor at hand.

Limitations of the present study and suggestions for future research

One shortcoming of the study is that the nature of the marital relationship participants had with their spouses, which is probably the most important factor in determining the nature of the expression of bereavement, was not investigated. Factors such as marital satisfaction, whether the husband was living with the bereaved at the time he died, and, most importantly, the role the husband played in the life of the bereaved spouse, should be investigated in future research. The latter point is important, given the high unemployment rate in the rural areas. To this effect, it would be erroneous to assume that the death of the husband caused the loss of the family's source of income. Therefore, exploring this critical factor would be as important in understanding the nature of bereavement as much as it is to understand the presence of both depressive and anxiety symptomatology as well as the strategies used to deal with grief by rural black South African women.

Another limitation of the study is that it was restricted to women, so that the question of gender differences with regard to the expression of bereavement could not be explored. Thus, it would be important for future researchers to investigate whether

temporary disavowal of reality (avoidance) is a means of getting through the initial devastating early period of loss and threat, before reaching the later stage of acknowledgement and adjustment.

Given these two points of view, it is not surprising that a substantial number of participants in the present study made high use of avoidance coping strategies. It can be hypothesised that during the first six months after the husband's death, participants used avoidance as a temporary adaptive response that allowed them to cope with the initial shock while at the same time "buying" time to make the necessary cognitive and emotional adjustment to their new widowhood status.

From a divergent viewpoint, a South African study of HIV positive patients conducted by Stein (1996) found that avoidant coping strategies functioned as protective buffer against negative thoughts and related beliefs of hopelessness and helplessness. Stein's findings posed a vigorous challenge to the generally accepted notions about the preferability and desirability of problem-solving and social support-seeking coping strategies over the avoidant coping strategy, for the individual to effectively cope with the crisis at hand. Stein further maintained that in an African setting, where the emphasis is not on the personal or individual process - but rather on the socio-cultural context within which the individual functions - avoidance coping is generally viewed as adaptive.

While this may have been true for Stein's (1996) research population, it merits scrutiny and does not seem applicable to the findings of the present study, primarily because of the high incidence of participants' anxiety and depressive symptomatology, the scores of which were both significantly positively correlated with avoidant coping strategy scores. In similar vein, in the present study, an avoidant coping strategy emerged as a significant positive predictor of both depression and anxiety. Therefore,

any gender differences exist regarding stress and bereavement in rural black communities.

Thirdly, for the employed participants, the nature of job satisfaction was not explored, and it proved difficult to tell whether or not the hypothesized differences between the unemployed participants and those with paid work were due to chance.

Fourthly, the fact that a relatively small non-probability sample was used, limits the generalisability of the findings. It is therefore suggested that future research could replicate the present study with larger and more representative samples to expand the generalisability of the findings to the total population of recently widowed black women in South Africa.

Finally, future research should also pay attention to cross-cultural differences in the emotional manifestations of grief and coping strategies during the period following spousal bereavement.

Implications of the present study

An important implication of the present study is the increased need for continued bereavement treatment programmes (for example, therapeutic support groups) for recently bereaved women in the rural areas, given that people in these areas are inevitably confronted with the death of their spouses on an almost daily basis. Such treatment programmes would need to focus on training them in how to cope with the conjugal loss through death when it occurs. It would be particularly important to enable them to recognize how maladaptive avoidant coping strategies can be, and to psycho-educate them as to why substituting the more adaptive, active, practical problem-oriented as well as social support-seeking modes of coping for avoidant strategies is important. Practical ways of replacing the maladaptive coping strategies

with more functional ones should form an integral part of such bereavement treatment programmes.

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APPENDIX

The Social Support Scale (SSS)

Social Support Scale (SSS)

Following a traumatic event, some people receive emotional and social support from different important persons in their lives. In the following statements, please indicate the extent to which YOU received social support from your significant others since your husband's death. All statements are rated on a 5-point scale, with 1 indicating "never received support", and 5 indicating "always received support". You are requested to answer ALL questions, with only one mark per statement.

1	2	3	4	5
I never received support	I rarely received support	Uncertain/ Neutral	I received some support	I always received support

Keeping in mind the death of your husband and its aftermath, please rate how much support have you received from:

1. Your brothers.....	1	2	3	4	5
2. Your sisters.....	1	2	3	4	5
3. Your children (if any).....	1	2	3	4	5
4. Your parents-in-law.....	1	2	3	4	5
5. Your sisters-in-law.....	1	2	3	4	5
6. Your brothers-in-law.....	1	2	3	4	5
7. Your own parents (if still alive).....	1	2	3	4	5
8. Your cousins and other relatives.....	1	2	3	4	5
9. Your friends.....	1	2	3	4	5
10. Other widowed women.....	1	2	3	4	5
11. The church.....	1	2	3	4	5
12. The community organisations.....	1	2	3	4	5
13. The people in the neighbourhood.....	1	2	3	4	5
14. The work colleagues.....	1	2	3	4	5
15. Your late husband's friends.....	1	2	3	4	5
16. Your late husband's colleagues.....	1	2	3	4	5
17. Other women generally.....	1	2	3	4	5