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Coping Mechanisms of Elderly, Ill, Homebound Clients

by

Vivien Tune

A Thesis
Submitted to the Faculty of
Mississippi University for Women
in Partial Fulfillment of the Requirements
for the Degree of Master of Science in Nursing
in the Division of Nursing
Mississippi University for Women

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Coping Mechanisms of Elderly, Ill,

Homebound Clients

by

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Abstract

This study was a descriptive one whose purpose was to identify coping mechanisms used by elderly, ill, homebound clients. The sample included 30 home health clients in a small southern community. The average age of the subjects was 76 years. Data were collected using Coping Resources Inventory (Hammer & Marting, 1988) and a demographic and health history form. Data were analyzed using the mean, standard deviation, and Pearson *r*. Analysis of the data revealed that the elders utilized spiritual/philosophical, cognitive, social, and emotional coping skills equally and more often than physical coping skills. There were significant correlations between social coping skills and sex, marriage, and previous home health experience; between cognitive coping skills and the need for assistance with activities of daily living; between physical coping skills and diagnoses of diabetes or bone and joint disorders; and between total coping skills and previous home health experience. Recommendations for further study include investigation of the coping mechanisms of well and ill elders and the impact of nursing care on coping. Geriatric Nurse Clinicians should promote the use of a broad range of coping mechanisms to prevent crises.

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Chapter I

The Research Problem

Aging is a time marked by multiple losses and numerous life changes (Manfredi & Pickett, 1987). For instance, older people report more health-related problems than younger people (McRae, 1982). Accompanying these losses, there appears to be a decrease in the ability of elders to adapt to change and to cope with stress. The decrease occurs at a time when there is a corresponding increase in the number and intensity of stressors in the elderly person's life. Stressors common to elderly individuals include retirement and loss of social contacts, loneliness, diminishing health, mobility, energy levels, and financial resources, relocation, illness, loss of independence, death, and loss of significant others (Ebersole & Hess, 1985).

Stressors create stress reactions which can alter affect, behavior, cognition, and physiology. Stress reactions may include anxiety; depression; impaired perception, thought, and judgment; and increased blood pressure, heart rate, and respiration. In order to avert these stress reactions, coping is necessary.

Coping is adjusting and adapting successfully to meet stressors and reduce the level of stress. It is a

combination of conscious strategies and unconscious defense mechanisms which a person uses in adjusting to environmental demands or stressors without altering individual goals or purposes. Barry (1984) defined coping mechanisms as mental maneuvers used to protect a person from unwanted reality in the environment and help maintain intrapsychic stability during times of increased stress.

Mechanisms for coping with stress are as varied as the stress-inducing factors themselves (Manfredi & Pickett, 1987). Since no two humans ever respond emotionally in the same way to the same event, each person has a repertoire of defense or coping mechanisms that have been developed from the time of childhood. Psychologically, astute persons use conscious stress management techniques in response to the stress of day-to-day life. Such stress reduction techniques include jogging, meditation, exercising, and talking.

A stressor such as an illness can impose many new stressors. Because one has usually never experienced the stressor of illness before, a person does not have a repertoire of coping mechanisms to relieve that stress. As a result, a person's normal ability to cope regresses and that person uses more unconscious defense mechanisms. Denial, repression, projection, displacement, avoidance, and isolation are some of these defense mechanisms. If the person does not cope well, continued unsuccessful coping attempts can result in crisis. Feelings of helplessness,

lack of control, and dependency emerge. When crises are overcome with or without intervention, a higher level of coping skills usually develop and become part of a person's coping repertoire for future challenges (Barry, 1984).

Elders are more likely to encounter the stress of an illness, and they have fewer intact resources than younger individuals to meet that stress. For example, approximately 18% of persons over 65 live beneath the poverty level on fixed incomes from Social Security and retirement benefits and must cope with the problems of adequate housing and financial management. In addition, elders must use their limited resources to cope with stressors such as maintaining social contacts, depending on public transportation, gaining access to continuous health care, maintaining nutrition, and combating stereotypes and myths imposed by a youth-oriented society (Manfredi & Pickett, 1987).

There is a need to analyze the coping mechanisms of elders and the manner in which health is affected. Older people have been portrayed as rigid and unable to adapt or as using passive and ineffective mechanisms. Also, older people have been portrayed as using defense mechanisms that are increasingly more effective and less distorting of reality than younger people (Manfredi & Pickett, 1987). The fact that individuals over the age of 65 have been excluded and underrepresented in coping studies could account for these conflicting views (McRae, 1982). Another factor to

consider is the fact that scales relating to coping in geriatrics are still in early experimental stages (Kane & Kane, 1981).

There is a critical need for nurses who work with elders to identify coping mechanisms and behaviors exhibited by their clients and to assess whether these behaviors are potentially adaptive or maladaptive. Based on this assessment, the identified coping behaviors should either be reinforced or extinguished and other behaviors substituted. The nurse can provide the elder with an environment in which personal coping mechanisms may be utilized and strengthened (Garland & Bush, 1982). In addition, nurses are often better prepared to initiate stress management programs in health promotion, maintenance, and restoration because of their educational preparation and intimate and comprehensive knowledge of evidence of stress in clients. Nurses have extended clinical contact with clients and their families and a unique opportunity for empirical observation and effective practice outcomes to serve as a base for research on stress and coping (Sutterley, 1986).

Problem Statement

The researcher has noted that the number of patients being released from the hospitals and relying on care by home health nurses has increased since the enforcement of DRG regulations. A large percentage of these patients are over the age of 55. Since all patients receiving home

health care must have a medical problem which renders them homebound and requires services of a skilled nurse (Mississippi Health Care Commission, 1982), all home health patients are coping with stressors due to illness. Due to illness, many elders are forced to move from their homes to be cared for by family members or friends, thus adding additional stress to tax their coping mechanisms. Over the past 4 years, the researcher has noted the ability of some clients to cope better than other clients. However, the nurse's knowledge of coping behavior of the elderly homebound has not kept pace with the increasing number of clients requesting assistance.

By identifying the coping mechanisms which elderly ill homebound clients use most often, nurse clinicians can promote positive coping mechanisms. Awareness of the use of inappropriate coping mechanisms can assist the clinician to effectively intervene and direct the client toward appropriate coping mechanisms. The result of decreased stress will increase the physical and psychological health of the elder. Therefore, the question this study sought to answer was: What are the coping mechanisms of elderly ill homebound clients?

Definition of Terms

For the purpose of this study, the following terms are defined:

1. Coping mechanisms: behaviors used by individuals to attempt to alleviate, attenuate, or remove stressors (Garland & Bush, 1982).

2. Elderly: people at least 55 years of age.

3. Ill: of unsound physical health; unwell; sick (Stein, 1984).

4. Homebound: individuals unable to drive or leave home without assistance (Mississippi Health Care Commission, 1982).

Assumptions

The following assumptions have been made:

1. Elders have the ability to cope with stressful situations and have developed some coping mechanisms.

2. Coping mechanisms can be identified.

Chapter II

Theoretical Basis of Study

The theoretical concepts of Betty Neuman's systems model served as a guide for this research of coping mechanisms of elderly, ill, homebound clients. Neuman developed a health care systems model that provides a total approach to client care. Neuman's model focuses on the total person's reaction to stress and specifies intervention modes for organizing the nature of the action that the nurse or other health care provider can use for stress reduction or prevention (Sutterley, 1986).

Neuman's model focuses on the person as a complete system with interrelated subparts of physiologic, psychological, sociocultural, and developmental factors. The variables interact to determine the amount of resistance an individual can use against stressors. The stressors may be intrapersonal, interpersonal, or extrapersonal (Neuman, 1982).

The central core of protection each person has to fight against stress consists of basic survival factors common to all people. The factors include mechanisms for maintenance of a normal temperature range, a genetic response pattern, and strengths and weaknesses of various body parts and

organs (Neuman, 1974). The first line of defense a person has against stressors is a flexible line of resistance. Internal factors of white blood cells and immune response mechanisms that help the body defend against stressors are part of the flexible line of resistance. The next protective barrier is the normal line of defense, which includes the person's coping style, development stage, and lifestyle. The final buffer against stressors is the flexible line of defense, composed of dynamic factors that can fluctuate in response to circumstances.

The person maintains balance and harmony between internal and external environments by adjusting to stress and by defending against tension-producing stimuli. Wellness is equated with equilibrium and is maintained when the person's flexible line of defense has prevented stressors from penetrating the normal line of defense (Neuman, 1982). Multiple impact of stressors can reduce the effectiveness of this buffer system and allow a reaction from one or more stressors to occur (Neuman, 1974).

Neuman believes that stressors are different in their potential to disturb an individual's equilibrium or normal line of defense. Nursing is seen as a unique profession concerned with all the variables affecting an individual's response to stressors. The aim of the model is to understand man and his environment and to provide a unifying focus for approaching varied nursing problems.

Neuman's model focuses on intervention modes to organize the nature of action, which the nurse uses to assist with stress reduction or prevention (Sutterley, 1986). Neuman believes that nursing intervention may be carried out at primary, secondary, or tertiary levels. She believes that each individual over time has developed his own normal range of responses to stressors referred to as a normal line of defense. These responses or coping mechanisms have not been identified by Neuman (Neuman, 1974). The aim of this research was to identify the normal line of defense for elders who are stressed by illness. By identifying normal lines of defense, the nurse can intervene when stressors render the line of defense ineffective. Stress reduction can only be instigated after the nurse identifies the coping mechanisms the individual is using to reduce stressors.

Chapter III

Review of Literature

Concern about the health consequences of stress has prompted researchers to explore what constitutes stress and coping. To understand the consequences of stress, it is necessary to analyze the mechanisms through which coping affects health (Sutterley, 1986). The growing population of elderly people is an extremely vulnerable group, because they have fewer intact resources than younger individuals (Manfredi & Pickett, 1987). Unfortunately, there is only a small amount of literature published on age differences in coping (McRae, 1982) and very few studies about coping with illness. The studies that were available and included in this review of literature are two targeted at coping in the elderly and one on coping of the functionally disabled.

In a descriptive study, Folkman and Lazarus (1980) analyzed the way 100 community-residing men and women aged 45 to 64 coped with stressful events of daily living during one year. Forty-eight of the 100 participants were ages 55 and 64. Information about recently experienced stressful encounters was elicited through monthly interviews. Self-report questionnaires were completed between interviews. At the end of each interview, the participants indicated on a

68-item Ways of Coping Checklist those coping thoughts and actions used in the specific encounter. Two functions of coping, problem-focused and emotion-focused, as identified in previous coping research, were chosen to analyze the separate measures.

Folkman and Lazarus (1980) found that emotion-focused coping was favored in health contexts. Situations in which the person thought something constructive could be done or that were seen as requiring more information, favored problem-focused coping, whereas the situations that had to be accepted favored emotion-focused coping. There were no effects associated with age. There was a trend for older participants to report more health-related episodes and fewer family and work episodes than younger ones. The trend suggested that as sources of stress began to change with advancing age, differences in coping might emerge as a function of the changes in sources of stress. The study recommended that comparisons with more elderly samples were needed to determine if there are changes in coping associated with aging, and if so, whether those changes were better understood as a function of changes in sources of stress or of changes in personality.

Manfredi and Pickett (1987) conducted a descriptive study designed to elicit information regarding the types of stressful situations experienced by the elderly and the coping strategies utilized to deal with the stress. The

sample consisted of 51 individuals 60 years of age or older. Participants were asked to describe event experienced within the past month. Then they completed the Ways of Coping Checklist, which involved selection of strategies for coping with the stressors they had identified. Stressful events most often identified were loss and conflict. Losses included loss of health, loss of significant relationships, and loss of economic resources. The major area of conflict was the issue of power/control. A wide variety of both problem-focused and emotion-focused strategies were utilized by the participants.

Prayer was reported as the most frequently used coping strategy among the participants. In addition to prayer, the elderly were more inclined to utilize other inspirational strategies, such as believing things could be worse, looking for the "silver lining," and maintaining pride. Manfredi and Pickett (1987) recommended that additional studies be conducted on the elderly population to determine coping strategies utilized by the elderly.

McNett (1987) studied social support, threat, and coping responses as they related to effectiveness in the functionally disabled. The sample consisted of 50 wheel-chair bound subjects ranging in age from 18 to 64 with a mean age of 37.4 years. Social support variables were hypothesized to effect coping responses both directly and through the variable of threat appraisal. Coping responses

were hypothesized to directly affect coping effectiveness and to mediate the effect of all other variables. Coping responses were measured by the Ways of Coping Checklist. Coping effectiveness was measured by the McNett Coping Effectiveness Questionnaire designed and tested by the researcher. The perceived availability of social support was measured by the Interpersonal Support Evaluation List, using the tangible, informational, and belonging scales. The perceived effectiveness of social support and degree of threat were measured by interviewing the subjects.

Findings indicated that perceived availability of social support, but not the use of social support, was significantly and positively related to coping effectiveness through the mediating variables of problem-focused and emotion-focused coping. The author recommended further studies be performed on different populations.

McRae (1982) reported finding only a small amount of literature on age differences and the use of coping mechanisms and concluded that individuals over the age of 65 years were excluded or underrepresented in coping studies. He noted the aging individuals are often stereotyped as lacking ability to adapt to stressful situations and are often portrayed as being rigid in their responses or as using regressive defense mechanisms that distort reality.

McRae (1982) related findings of two cross-sectional studies on the subject of age differences in the use of

coping mechanisms. The studies were done to determine the types of coping mechanisms people used. One set of hypotheses suggested elders regressed and used isolation of affect, intellectual denial, self-blame, withdrawal, wishful thinking, passivity, and assessing blame most often. The other hypothesis suggested that as age increased immature mechanisms, such as hostile reactions, escapist fantasy, assessing blame, self-blame, and passivity decreased and mature mechanisms increased.

In the first study of healthy volunteers, the sample included 255 subjects who had reported a recent life event classifiable as a loss, threat, or challenge. Eighty-one subjects were 50 to 64 years of age, and 86 subjects were 65 to 91 years of age. The instruments used were the Ways of Coping Checklist and a coping questionnaire designed by the researcher.

Results showed no evidence that mature and effective coping responses, such as positive thinking, self-adaptation, and humor, were more frequent in the middle-aged group than both younger and older persons. There was no evidence that the use of theoretically mature mechanisms increased with age. To strengthen the interpretation of results, a second study was conducted in an effort to replicate the findings.

The second study consisted of 150 participants selected from a subgroup of the participants in the first study.

However, the new participants had not reported an event in the previous year that could be classified as a challenge. Of the 150 subjects, 97 were 50 to 90 years of age. Subjects were asked to complete a questionnaire consisting of three parts. The three parts were coping with harm of loss, coping with threat, and coping with challenge. Subjects also completed the coping instrument designed by the researchers for the previous study.

Both studies confirmed the decline with age in the use of hostile reactions and escapist fantasy. Results showed that the older people, in the samples, coped in much the same way as the younger people, and that, where they employed different mechanisms, it appeared to be largely because of the different types of stressors encountered. The author proposed that as individuals age, they may learn to eliminate coping responses that are found to be ineffective. McRae (1982) conceded that quite different results might have been seen in a sample of sick or disadvantaged people.

Summary

Little research was found on how elders cope. One study determined that the sources of coping and not the coping mechanisms change as people age. Anther study identified prayer and inspirational coping as strategies used more often by elders. One researcher found perceived social support and coping effectiveness were positively

related. McRae (1982) tested two conflicting hypotheses and found that older people coped in much the same way as younger people, but encountered different types of stressors. He proposed that elders eliminated ineffective coping mechanisms as they aged. No coping research was found on ill or homebound elders and how they cope with stress. All authors recommended the need for further coping research to determine how elders cope under different stressors. It would, therefore, seem highly desirable to conduct research to identify what coping mechanisms elderly, ill, homebound clients use to deal with stress.

Chapter IV

Research Design and Methodology

Research Design

A descriptive study design was used to examine coping mechanisms of elderly ill clients who were homebound. Descriptive research studies have as their main objective the accurate portrayal of the characteristics of persons, situations, or groups, and the frequency with which certain phenomena occurs (Polit & Hungler, 1987). This research was an attempt to portray the coping characteristics or mechanisms of a specific group of people and to document the frequency that these mechanisms were used in the specific population. Demographic variables were also considered.

Variables

The variable of interest was coping mechanisms. Controlled variables in this study were age, hearing capacity, illness, mental capacity, and homebound status. All subjects had to be at least 55 years of age with a current illness. The subjects had to be homebound and unable to drive due to illness or functional disability. An alert and oriented mental status was required to understand, contemplate, and answer the questionnaire. Clients who had

severe hearing deficits were not chosen due to the importance of understanding the questions.

Intervening variables included the different stressful events clients had experienced and the number of times clients had coped with stressors. Other variables that could not be controlled were the individual interpretations of the questions on the questionnaire and the specific events on which the clients chose to base their responses.

Setting, Population, and Sample

The setting for this study was a small community in Southern Mississippi and the surrounding rural area. The county has a population of 20,366 people (Vital Statistics Mississippi, 1986). The largest town in the county has a population of 3,708 people, with 1,671 males and 2,037 females. There are 1,552 whites and 2,156 nonwhites. The population age 55 years and over is 1,031 (United States Department of Census, 1980).

In the county, there are numerous home health agencies. One of these agencies was chosen for selecting a sample of ill homebound elders. This home health agency serves between 60 and 70 clients. The agency does not discriminate because of age, sex, race, or religion. The population for this study was all home health clients of this agency who were age 55 years and above. Potential subjects were referred by home health nurses who were informed of the subject criteria. The researcher then contacted the

potential subjects and invited their participation in the study. The result of this process was a convenience sample of 30.

Data-Gathering Process

Verbal permission to use the agency was obtained from the administrator. Those clients the home health nurses identified as potential participants were contacted by telephone and given a brief overview of the proposed research. If clients were interested in participating, the researcher visited them in their homes to further explain the study and answer any questions about it. If clients were interested in participating, a consent form was signed and a demographic and health history form was completed (see Appendices A and B). After consent and demographic information were obtained, the Coping Resources Inventory was read and responses recorded on an answer sheet by the researcher (see Appendix C). Two of the 30 subjects chose to read the questionnaire themselves and mark their own answer sheets. It required 30 to 60 minutes for subjects to complete the questionnaires. The time frame for data collection was 2 weeks during May.

Instrumentation

The Coping Resources Inventory (CRI), developed by Hammer and Marting (1988), was used in this study. The 60-item questionnaire was designed to measure personal

resources for coping with stress and consists of five scales measuring the cognitive, social, physical, emotional, and spiritual/philosophical resources of individuals. The tool identifies resources an individual may already possess that can be used to cope with stress and areas where resources may need to be strengthened. The CRI was constructed to facilitate an emphasis on resources rather than deficits.

In using the CRI, subjects are asked to respond to 60 items by indicating the frequency of engaging in certain behaviors or the frequency with which the statements are personally applicable. For each of the 60 items, respondents use a 4-point scale to indicate how often they have engaged in the behavior described in the item over the past 6 months. Scale scores are simply the sum of the item responses for each scale. Points for six items with negative wording must be reversed, however, before adding the points to the scale score. In addition to the five individual scale scores, a Total Resource score is computed by summing the five scale scores. The higher the scale score, the higher the resource. Since the scales have different numbers of items, direct comparisons among scales based on raw scores are not possible. The raw scores are converted to standard scores having a mean of 50 and a standard deviation of 10 points. Internal consistency reliability ranges from .89 to .94. The CRI Total Resource score has been found to be a significant incremental

predictor of stress symptoms (R^2 change = .15, $p < .0001$). Validity coefficients, or correlations of the same traits across methods, have provided evidence for convergent validity, ranging from .61 for the Spiritual/Philosophical scale to .80 for the Physical scale (Hammer & Marting, 1988).

Analysis of Data

Descriptive statistics were used to describe and summarize the accumulated data. Raw scores were converted to standard scores having a mean of 50 and a standard deviation of 10 points. The product moment correlation coefficient, or Pearson *r*, is the most commonly used linear correlation index (Polit & Hungler, 1987) and was used to analyze correlations between the demographic data and the CRI coping scores. An alpha level of .05 was chosen.

Limitations

The limitations of this study were identified as the:

1. Inability to generalize to the whole population of elders due to the small sample size.

2. Inability to generalize to elders in different geographic areas.

3. Inability to generalize to patients of all home health agencies.

4. Inability to generalize to the whole population of elders who are not on home health services.

Chapter V

Analysis of Data

The purpose of this descriptive study was to identify coping mechanisms of elderly, ill, homebound clients. The sample consisted of 30 clients from a home health agency located in a small southern community. Data were collected using a demographic health history sheet and the Coping Resources Inventory (CRI) (Hammer & Marting, 1988). Raw scores were converted to standard scores with a mean of 50 and a standard deviation of 10. The standardized scores were correlated to various demographic factors using Pearson *r*.

Of the 30 subjects, 18 (60%) were white and 19 (63%) were females. The ages ranged from 76 to 89 years with a mean age of 76 years. Half of the subjects were married. Educational level ranged from 0 to 16 years with a mean education of 9 years, and the mean income was between $300 and $400 per month. Subjects had been receiving home health services an average of 11.3 months and 7 (23%) had previously received home health services. Nineteen (63.3%) of the subjects needed assistance with activities of daily living. Data from the health history revealed that many clients had more than one diagnosis. Fifteen (50%) of the

clients reported diabetes; 21 (70%), bone and joint disorders; 25 (83.3%), cardiac problems; 23 (76.7%), cancer; 19 (63.3%), respiratory difficulties; and 6 (20%), cerebrovascular accident. These data are shown in Table 1.

The standardized scores on the cognitive subscale ranged from 23 to 69 with a mean of 60.1. Social scores ranged from 16 to 74 with a mean of 59.6. Emotional scores ranged from 35 to 77 with a mean of 59.6. Spiritual/philosophical scores ranged from 39 to 71 with a mean of 60.37. Physical scores ranged from 38 to 72 with a mean of 52.13. Total scores ranged from 25 to 76 with a mean of 61.43 (see Table 2).

Additional Findings

Data analysis using Pearson's r at .05 level of significance revealed several significant correlations between demographic data and scores on the coping scales. A negative correlation was found between females and social coping skills (r = -.465, p = .005), marriage correlated positively with social coping skills (r = .388, p = .017), previous home health experience correlated negatively with social coping skills (r = -.378, p = .02), and with total coping scores (r = -.368, p = .02), and individuals requiring assistance with activities of daily living correlated negatively with cognitive coping skills (r = -.312, p = .05). A diagnosis of diabetes was positively correlated

Table 1

Demographic Data and Standardized Scores on the Coping Resources Inventory

Subject	Race[a]	Age	Sex[b]	Marital Status[c]	Income[d]	Education (Months)	Time on Home Health (Months)	Time on previous Home Health (Months)	Assistance with ADL[e]	Diabetes[f]	Bone/Joint[g]
1	0	78	1	1	7	16	1	0	1	0	1
2	0	78	1	0	2	11	30	0	1	0	1
3	0	60	0	0	6	13	7	0	1	1	0
4	1	88	1	0	2	0	4	0	0	1	1
5	0	76	1	0	7	16	21	0	1	0	1
6	1	83	1	0	3	8	16	0	1	1	1
7	0	78	0	1	2	7	26	0	1	1	1
8	0	69	1	1	4	12	1	0	0	1	1
9	0	69	0	1	2	4	22	0	0	0	1
10	0	83	0	0	3	12	16	0	0	1	0
11	0	81	1	1	7	16	2	0	0	0	1
12	0	83	0	1	7	12	1	7	0	0	1
13	0	79	0	1	5	16	6	0	1	0	1

[a]Race: White = 0, Nonwhite = 1. [b]Sex: Male = 0, Female = 1. [c]Marital Status: No = 0, Yes = 1. [d]Income: 1 = $100-$200, 2 = $200-$300, 3 = $300-$400, 4 = $400-$500, 5 = $500-$600, 6 = $600-$700, 7 = $700 or More. [e]ADL = Require assistance with activities of daily living. 0 = No, 1 = Yes. [f]Diabetes: 0 = No, 1 = Yes. [g]Bone/Joint: 0 = No, 1 = Yes. [h]Cardiac problems: 0 = No, 1 = Yes. [i]Cancer: 0 = No, 1 = Yes. [j]Respiratory Problems: 0 = No, 1 = Yes. [k]Cerebrovascular accident: 0 = No, 1 = Yes.

Subject	Race	Age	Sex	Marital Status	Income	Education (Months)	Time on Home Health (Months)	Time on previous Home Health (Months)	Assistance with ADL	Diabetes	Bone/Joint
14	1	73	0	1	3	2	3	2	1	1	0
15	0	78	1	0	3	14	34	15	1	1	1
16	1	79	1	0	2	6	5	0	1	1	0
17	1	68	1	0	3	7	36	0	0	1	1
18	0	83	1	0	4	8	3	0	1	1	0
19	1	77	1	0	3	9	6	0	1	1	0
20	1	63	1	1	1	2	13	0	0	0	1
21	0	77	0	1	6	11	20	4	1	1	0
22	1	86	1	0	3	5	2	6	1	0	1
23	1	60	1	0	3	9	6	8	1	0	0
24	0	89	1	0	4	8	12	17	1	0	1
25	0	77	1	1	1	10	2	0	0	0	1
26	1	73	0	1	3	12	18	0	0	0	1
27	1	77	0	1	3	4	3	0	1	0	1
28	1	58	1	1	2	4	4	0	1	1	1
29	0	70	0	1	6	15	11	0	0	1	1
30	0	89	1	0	1	8	8	0	1	0	0

Subject	Cardiac problems[h]	Cancer[i]	Respiratory problems[j]	Cerebro-vascular accident[k]	Coping Resources Inventory Score					
					Cognitive	Social	Emotional	Spiritual/ philosophical	Physical	Total
1	1	0	0	0	49	55	62	54	48	57
2	1	0	0	0	60	64	67	64	54	67
3	1	1	0	0	60	67	54	53	72	64
4	1	0	0	0	62	54	62	65	47	61
5	0	0	0	0	58	64	65	62	49	63
6	1	0	1	0	49	45	48	52	51	49
7	1	1	0	0	62	67	58	56	38	59
8	0	0	0	0	58	57	56	54	42	55
9	1	0	1	0	55	67	60	51	58	62
10	0	0	1	0	69	67	75	66	70	76
11	1	0	0	0	66	63	66	61	54	66
12	1	1	0	0	69	74	77	71	55	76
13	0	1	1	0	67	61	68	61	45	65

Subject	Cardiac problems	Cancer	Respiratory problems	Cerebro-vascular accident	Coping Resources Inventory Score					
					Cognitive	Social	Emotional	Spiritual/ philosophical	Physical	Total
14	1	0	1	1	62	67	77	71	60	75
15	1	0	1	0	23	16	35	39	38	25
16	1	0	0	0	68	64	58	64	67	68
17	1	0	1	1	66	63	73	64	62	71
18	1	1	1	0	47	55	51	62	54	56
19	1	0	1	1	58	50	59	57	54	58
20	1	1	1	0	68	59	52	62	43	59
21	0	0	1	1	60	64	63	61	56	65
22	1	0	1	1	53	55	48	57	45	52
23	1	0	1	0	64	50	47	59	40	52
24	1	0	1	0	68	66	59	62	51	65
25	1	0	1	0	62	59	63	52	54	61
26	1	0	1	0	69	69	53	65	38	61
27	1	0	1	1	49	57	45	63	38	50
28	1	0	1	0	68	70	73	69	60	74
29	1	0	1	0	60	66	58	70	55	65
30	1	1	0	0	64	63	56	64	66	66

with physical coping skills (r = .308, p = .05), and a diagnosis of bone and joint problems correlated negatively with physical coping skills (r = -.533, p = .001).

Table 2

Standardized Means and Standard Deviations for Scores on the Coping Resources Inventory

Coping Skill	n	M	SD
Cognitive	30	60.10	9.68
Social	30	59.60	10.66
Emotional	30	59.60	10.03
Spiritual/philosophical	30	60.37	6.96
Physical	30	52.13	9.69
Total		61.43	10.07

Chapter VI

Summary, Implications, and Recommendations

Summary

This study was a descriptive one whose purpose was to identify coping mechanisms used by elderly, ill, homebound clients. The sample included 30 home health clients in a small southern community. The average age of the subjects was 76 years. Data were collected using Coping Resources Inventory (CRI) (Hammer & Marting, 1988) and a demographic and health history form. Data were analyzed using the mean, standard deviation, and Pearson *r*. Analysis of the data revealed that the elders utilized spiritual/philosophical, cognitive, social, and emotional coping skills equally and more often than physical coping skills. There were significant correlations between social coping skills and sex, marriage, and previous home health experience; between cognitive coping skills and the need for assistance with activities of daily living; between physical coping skills and diagnoses of diabetes or bone and joint disorders; and between total coping skills and previous home health experience.

Implications

The findings of this study indicate that the elders had better than average coping skills. This finding may be the result of the nursing care by home health nurses these subjects received. The nursing care may have increased coping skills while simultaneously reducing the stress of illness for the clients. Further research is needed to compare elderly, ill, homebound clients who do not receive home health services to those who do and thus determine the impact of nursing care on coping.

The higher than average CRI scores seem to support McRae's (1982) findings that as individuals age they may learn to eliminate ineffective coping responses. However, a longitudinal study of coping skills as people age is needed. Since coping skills appear to become more effective with age, nurses can capitalize on the coping skills of elders to assist younger clients with stressors that elders have dealt with successfully.

The lower physical coping scores of these subjects on the CRI is not unexpected, since subjects were ill and homebound. As a result of physical illness, elders used other coping mechanisms more frequently. This finding supports the findings of McRae (1982) and Folkman and Lazarus (1980) who found that elders use different coping mechanisms depending on the types of stress they face. Since physical coping skills are diminished in individuals

with physical illness, Geriatric Nurse Clinicians (GNCs) need to encourage other ways of coping with stress.

While the means of all but the physical coping scale were nearly equal, the mean of the spiritual/philosophical coping scale was slightly higher. This finding supports the findings of Manfredi and Pickett (1987) that prayer and inspirational strategies are frequently used coping mechanisms. Nurses can facilitate the spiritual coping skills of elders by encouraging them to read the Bible, watch religious programs on television, listen to religious broadcasts on the radio, invite friends and religious leaders to visit, and meditate.

This researcher has no explanation for the higher social coping scores of males but may be attributed to the small sample size. Further researcher needs to determine if males do use social coping skills more frequently than females. In the meantime, nurses need to encourage and support the use of social coping skills for males and to promote the use of social coping skills for females.

McNett (1987) identified the fact that social support increases the effectiveness of social coping. Therefore, the higher social coping scores for married individuals is expected. A spouse is an essential part of the social support system and is available to help deal with stressors. Nurses need to realize the importance and responsibility of the spouse as cornerstone of the social coping system of ill

individuals. There is a need for nursing assessment of the stress and coping mechanisms of the spouse. Appropriate nursing intervention is needed to prevent breakdown of the spouse due to the added stress of supporting an ill partner.

Lower social coping scores and lower total scores of individuals who had previously received home health services may indicate very poor health and exhaustion of coping skills. The idea that coping skills may become exhausted is supported by Neuman's theory regarding the flexible lines of defense. Thus, nurses need to evaluate ill homebound clients and remain alert for symptoms of exhaustion of coping skills so that nursing intervention and support of alternate effective coping mechanisms may be utilized to avoid a crisis situation.

This researcher has no explanation for the higher physical coping skills of diabetics or the lower cognitive coping skills of individuals who required assistance with activities of daily living. Further research needs to verify these findings and to explore the relationships.

The higher than average scores of the ill homebound sample reveal that, according to Neuman's open system model of stress and reaction, the subjects were coping well with the stress of illness. Various coping strategies were successfully utilized as lines of defense to avoid penetration of stressors to the basic structure of the individual.

These findings suggest that the subjects were progressing toward a state of reconstitution.

Recommendations

Based on the results of this study, the researcher makes the following recommendations:

Research

1. Replicate the study with a larger more representative sample.

2. Conduct a study comparing coping mechanisms of well and ill elders and the impact of nursing care on coping.

3. Conduct longitudinal studies to determine changes in coping skills.

4. Conduct a qualitative research study to determine the specific coping strategies ill elders use.

5. Conduct a study to investigate the impact of sex and marital status on coping.

Nursing

1. Assess coping skills of ill elders.

2. Encourage the use of a broad range of coping mechanisms.

3. Evaluate for exhaustion of coping skills and intervene to avoid crisis.

4. Support and promote the use of spiritual/philosophical coping skills for ill elders.

5. Capitalize on coping skills of elders to assist younger people to deal successfully with stress.

6. Assess stress and coping mechanisms of spouses of ill elders and intervene as indicated.

Appendix A

Informed Consent for Coping Research

Subject #_____

In signing this document, I am giving my consent to be a participant in the coping research of Vivien Tune, RN, graduate student at Mississippi University for Women. I understand that I will be part of a research study that will focus on the coping mechanisms of elderly ill homebound clients. This study will provide information to nurses who are trying to help elders better cope with illness.

I understand that I will be asked to complete a short demographic form and a 60-item questionnaire entitled Coping Resources Inventory. The questionnaire will take about 30 minutes to complete.

I give my consent freely. I have been informed that participation in this research is entirely voluntary. I understand that I can refuse to answer any specific questions and that I can withdraw my consent to participate at any point up to data analysis. I have been told that no reports of this study will ever identify me in any way. I have also been informed that my participation or nonparticipation or my refusal to answer questions will have no effect on services that I or any member of this family may receive from home health or other health service providers.

_____ _____

Date Respondent's Signature

_____

Researcher's Signature

Appendix B

Demographic Information for Coping Research

Subject #_____

Please complete the following:

1. Race: White___ Black___ Indian___ Asian___ Other___

2. Age: _____

3. Sex: Male___ Female___

4. Marital Status: S___ M___ W___ S or D___

5. Religious choice: _____

6. Monthly income:

$100 - $200	____	$500 - $600	____
$200 - $300	____	$600 - $700	____
$300 - $400	____	$700 or more	____
$400 - $500	____		

7. Highest grade completed in school:_____

8. How long have you been on this home health service?
____months _____weeks

9. Have you previously used home health services?
___Yes ___No

10. Do you need assistance with any activities of daily living? ___Yes ___No

11. What current health problems are bothering you the most?
_____

12. Brief health history (to be completed by researcher):

Coping Resources Inventory – Form D

Allen L. Hammer, Ph.D. and M. Susan Marting

Directions

For each of the sixty statements that follow, fill in the circle on your answer sheet that best describes you in the last six months. For each statement mark one of the following descriptions:

Never or rarely
Sometimes
Often
Always or almost always

Do not make any marks in this booklet. Mark all of your answers on the separate answer sheet. It is important that you try to answer every question.

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N = Never or rarely
S = Sometimes
O = Often
A = Always or almost always

31. I can say what I need or want without putting others down.
32. I accept problems that I cannot change.
33. I know what is important in life.
34. I admit when I'm afraid of something.
35. I enjoy being with people.
36. I am tired.
37. I express my feelings clearly and directly.
38. Certain traditions play an important part in my life.
39. I express my feelings of joy.
40. I can identify my emotions.
41. I attend church or religious meetings.
42. I do stretching exercises.
43. I eat well-balanced meals.
44. I pray or meditate.
45. I accept my feelings of anger.
46. I seek to grow spiritually.
47. I can express my feelings of anger.
48. My values and beliefs help me to meet daily challenges.
49. I put myself down.
50. I get along well with others.
51. I snack between meals.
52. I take time to reflect on my life.
53. Other people like me.
54. I laugh wholeheartedly.
55. I am optimistic about my future.
56. I get enough sleep.
57. My emotional life is stable.
58. I feel that no one cares about me.
59. I am shy.
60. I am in good physical shape.

N = Never or rarely
S = Sometimes
O = Often
A = Always or almost always

1. I have plenty of energy.
2. I say what I need or want without making excuses or dropping hints.
3. I like myself.
4. I am comfortable with the number of friends I have.
5. I eat junk food.
6. I feel as worthwhile as anyone else.
7. I am happy.
8. I am comfortable talking to strangers.
9. I am part of a group, other than my family, that cares about me.
10. I accept the mysteries of life and death.
11. I see myself as lovable.
12. I actively look for the positive side of people and situations.
13. I exercise vigorously 3-4 times a week.
14. I accept compliments easily.
15. I show others when I care about them.
16. I believe that people are willing to have me talk about my feelings.
17. I can show it when I am sad.
18. I am aware of my good qualities.
19. I express my feelings to close friends.
20. I can make sense out of my world.
21. My weight is within 5 lbs. of what it should be.
22. I believe in a power greater than myself.
23. I actively pursue happiness.
24. I can tell other people when I am hurt.
25. I encourage others to talk about their feelings.
26. I like my body.
27. I initiate contact with people.
28. I confide in my friends.
29. I can cry when sad.
30. I want to be of service to others.

Subject # _____

DIRECTIONS

In the spaces below, mark the circle that best describes you in the last six months. Do not spend too much time on any one question and try to answer all the questions.

	Never or rarely (N)	Sometimes (S)	Often (O)	Always or almost always (A)
1	N	S	O	A
2	N	S	O	A
3	N	S	O	A
4	N	S	O	A
5	N	S	O	A
6	N	S	O	A
7	N	S	O	A
8	N	S	O	A
9	N	S	O	A
10	N	S	O	A
11	N	S	O	A
12	N	S	O	A
13	N	S	O	A
14	N	S	O	A
15	N	S	O	A
16	N	S	O	A
17	N	S	O	A
18	N	S	O	A
19	N	S	O	A
20	N	S	O	A
21	N	S	O	A
22	N	S	O	A
23	N	S	O	A
24	N	S	O	A
25	N	S	O	A
26	N	S	O	A
27	N	S	O	A
28	N	S	O	A
29	N	S	O	A
30	N	S	O	A
31	N	S	O	A
32	N	S	O	A
33	N	S	O	A
34	N	S	O	A
35	N	S	O	A
36	N	S	O	A
37	N	S	O	A
38	N	S	O	A
39	N	S	O	A
40	N	S	O	A
41	N	S	O	A
42	N	S	O	A
43	N	S	O	A
44	N	S	O	A
45	N	S	O	A
46	N	S	O	A
47	N	S	O	A
48	N	S	O	A
49	N	S	O	A
50	N	S	O	A
51	N	S	O	A
52	N	S	O	A
53	N	S	O	A
54	N	S	O	A
55	N	S	O	A
56	N	S	O	A
57	N	S	O	A
58	N	S	O	A
59	N	S	O	A
60	N	S	O	A

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