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UNIVERSITY OF ALBERTA

THE RELATIONSHIPS OF ELDERLY HUSBANDS OF CANCER PATIENTS: A GROUNDED THEORY ANALYSIS

BY

KEITH WARREN CARLSON

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY.

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1994

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DEDICATION

I dedicate this dissertation in loving memory of my grandparents

Walter and Rhoda Hagstrom
Gunnar and Ruth Carlson

Each had a profound influence on my life
and kindled my interest in "things geriatric."

Abstract

In the past decade, the interest in caregivers of frail elderly people has proliferated. However, limited attention has been directed toward the experiences of male caregivers of elders with chronic illnesses; particularly non-dementia illnesses. Psychosocial oncology researchers have recognized the impact of cancer on the afflicted person's relationships but little is known about the impact of cancer on the caregiver's relationships. The social support literature has generally demonstrated that a caregiver's well-being is impacted by the frequency and type of support received but these quantifiable descriptors reveal little about how recipients themselves process exchanges within relationships. The purpose of this study was to generate substantive theory about the experiences of elderly husbands of cancer patients in terms of the impact cancer has on their relationships with wives, family, and friends as well as the nature of the relationships that husbands form with their wives' health care professionals.

Eight participants were interviewed utilizing an open ended format and the data were analyzed in accordance with grounded theory methodology. The main concern of participants emerging from the data was how they could best assist their wives under the circumstance of health deterioration. The basic means by which they attempted to resolve this concern was through the social psychological process of "dovetailing resources."

Participants differentiated between the responsibility they assumed for their wives' care and their own personal care. Central to the process at both of these marital and individual levels was the preference for self-sufficiency and the conditions that influenced the participants' decisions to request assistance from external resources (i.e., through their relationships with family, friends, neighbors, wife's formal network, and for some, the spiritual realm). "Dovetailing resources" reflects the process of maintaining the optimum level of self-sufficiency possible while recognizing the need for other people and accessing them in light of perceived personal limitations. The responses (e.g., providing solicited assistance) of these sources were also considered in the process of dovetailing resources as participants reevaluated the extent to which they could maintain their optimum level of self-sufficiency.

Dovetailing resources also integrates the marital and individual levels in that the process enables participants to experience a degree of autonomy at the

individual level despite increased dependency on other people at the marital level. Assistance can be requested on behalf of wives and/or partnerships thereby preserving autonomy at the individual level as the need for personal assistance is couched in broader terms.

ACKNOWLEDGMENTS

This dissertation would not have been possible without the assistance of many people. I am unable to acknowledge the participants by name out of respect for confidentiality but I am very grateful for their willingness to engage in this research process with me. I was continuously inspired by their devotion to life in the midst of adversity and value the relationships we established in a short period of time.

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I had the good fortune of crossing paths with three colleagues who were also interested in qualitative research. I learned much from Bernadette Laframboise and Howard Saslove and appreciated their willingness to listen and offer suggestions. Rhonda Gora helped me throughout my project and in particular, during the final stages of the process. She had already demonstrated that it could be done and offered suggestions enabling me to see this possibility for myself.

Throughout my academic endeavors, I have been blessed by the understanding support of friends and family. They have helped me to keep my life in perspective when I became too preoccupied with academia. Family members have enriched my life and demonstrated their concern for me in diverse ways. I would not have been able to complete my program without the enacted love from my parents and parents-in-law in particular. Their continual words of support, prayers, and tangible expressions of their concern for me and my family enabled me to persevere when the challenges seemed insurmountable.

Finally, I wish to acknowledge the unfaltering sacrifices of my wife, Diane. She has spent many hours typing for me throughout my training including transcribing and typing for this dissertation. She provided ongoing encouragement to me and undertook the most difficult - and most important - role as parent without as much assistance from me as we would have hoped while I completed this program. I love you and thank you from the bottom of my heart. I look forward to writing the next chapter of my life with you, Steven, Meredith, and Victoria.

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CHAPTER I: INTRODUCTION

Statement of Problem and Purpose of Study

It is well documented that families play a significant role in caring for elderly family members afflicted with chronic mental and physical illnesses. However, the term "family" is misleading in that typically one primary caregiver is responsible for the care of the frail elder. Researchers have amply demonstrated that primary caregivers experience negative consequences as measured in the form of emotional and physical burden. As an aside, positive outcomes of caregiving have received less attention from researchers but are also evident. In light of current and projected health care service restructuring, it is likely that family caregivers will become more involved in the care of adult family members with illnesses. Therefore, it is of interest to further our understanding of their experiences. By expanding the knowledge of caregiver experiences, researchers may enable policy makers to respond more appropriately to the specific needs of caregivers (Abel, 1990).

The definition of "family" subsumes several relationships. In the gerontological literature addressing the impact of a frail elder's health on primary caregivers, "family" has often referred to female caregivers. This tendency reflects their greater likelihood of assuming a caregiving role upon the onset of an elder's disability. However, this likelihood is reduced significantly when the frail sample under study is comprised of elderly married women. Under these circumstances, husbands are most likely to provide care (Stone, Cafferata, & Sangl, 1987). To date, the specific experiences of elderly husbands of women suffering from chronic illnesses have received limited attention in the literature. As male life expectancies are lengthening for increasing numbers of individuals, it seems inescapable that more elderly husbands will face the prospect of living with a spouse afflicted with a chronic illness.

When male caregivers have been included in studies, they have usually been middle-aged. Their experiences are not necessarily generalizable to elderly husbands. For example, older spouses are more susceptible than younger spouses to health and strength declines associated with the demands of giving care in the home (Martens & Davies, 1990).

A review of the caregiving literature revealed that the bulk of information has been derived from samples of caregivers providing care to persons with dementia. The attraction of this topic to researchers is not surprising given the prolonged period of decline in cognitive and physical functioning associated with this type of impairment. However, dementia incidence rates are far lower than cancer rates and in comparison, much less is known about the latter in regard to the impact on caregivers. Therefore, in the present study, the focus was on elderly husbands of cancer patients.

Psychosocial oncology research has traditionally devoted considerable resources to examining the impact of cancer on patients. It has become more commonplace, however, for the scope of study to incorporate the realm of cancer's impact on families as well. The plight of elderly caregivers of cancer patients is little understood, mirroring the tendencies in the general gerontological literature to examine the cancer impact on "young" family members and failing to differentiate between young and old members (if the latter are included). As in the broader caregiving literature, elderly husbands in particular have received scant attention.

An additional consideration in psychosocial oncology is the phase of the patient's cancer. Most studies have examined family members of terminally ill patients receiving palliative care. As a consequence, less is known about the experiences of family members of patients currently receiving active treatment. It is this group that is the focus of the present study.

Relationships of Caregivers

In her review of the general caregiving literature, Abel (1990) concluded that "most studies are based on structured interviews, which are analyzed statistically, and they focus on two issues that lend themselves to quantification - the chores caregivers perform and the stress they experience" (p.140). She acknowledged the worthiness of such pursuits as, for example, attention has been drawn to the labor intensive work performed by informal caregivers. However, this narrow focus poses limits on our understanding of the caregiving experience and in particular, the context in which chores are performed; namely the context of personal relationships which encompasses the exchange of assistance between caregivers and patients.

Models of caregiving have been developed and include influences of situational variables on the levels of caregiving outcomes (e.g., burden and stress). Biegel, Sales, and Schulz (1991) discussed several caregiving models developed in the literature to account for how caregivers manage their stress in light of various factors. Most models recognize the caregiver's social resources and social support as very influential on their abilities to manage situations.

Unfortunately, researchers have addressed social support in diverse ways and as a concept, it suffers as a result of inconsistent definitions and measurement.

Gottlieb (1992) discussed how social support grew to become a quantifiable commodity in the literature. As a consequence, the study of social support lost the sense of dynamic interpersonal exchanges found in "real life" relationships with people. His observations are consistent with Abel's (1990) criticisms of the caregiving literature cited previously. Acts of assistance have frequently been divorced from the context of the relationships within which they occur. Thus, while we may be relatively certain that husbands, for example, receive more assistance from others than wife caregivers, we still know little about the process by which this exchange of assistance takes place. There is a need to understand more about the nature of relationships within which caregivers are involved.

The purpose of the present study was to generate substantive theory about the nature of relationships of eight elderly husbands of cancer patients with metastatic disease. As little is known about the experiences of elderly men in this regard, a discovery oriented approach was implemented as opposed to a verificational approach. Rather than testing hypotheses, the purpose of the present study was to generate hypotheses. In choosing this approach, I encouraged husbands to describe their experiences from their own perspectives.

The methodology employed in the present study was grounded theory as described by Glaser and Strauss (1967) and developed further by Glaser (1978; 1992). Grounded theory is detailed in Chapters II and III. Consistent with this methodology, I entered this area of interest with the abstract questions of what was the main issue of husbands in regard to their relationships and secondly, how they went about resolving the issue.

The abstract guiding research questions were modified as the study progressed to reflect the issues of the eight participants in the study. The basic issue for all of the participants was how they could best help their partners deal with health deterioration. The basic social psychological process (BSPP) of "dovetailing resources" emerged from the data analysis as the means by which participants resolved their issue. The dovetailing resources BSPP is overviewed and detailed in Chapter IV. Finally, the emergent theory is discussed in relation to existing theory and research in Chapter V. Limitations of the study, future research suggestions, and implications of the study conclude the chapter.

Personal Perspectives on the Study

In qualitative methodologies such as grounded theory, the investigator is the research instrument. Sandelowski (1986) noted the importance of addressing research trustworthiness in this light. One of her suggested steps is to inform readers how the researcher became interested in the study subject matter. This step, along with others described in Chapter III, enables readers to judge the study's trustworthiness as they are better informed about the "research instrument." Here, I provide information concerning my decision to study elderly husbands of cancer patients. In choosing this research topic, I was influenced by personal, academic, and professional experiences.

While I am a man and have witnessed firsthand the effects of cancer on family and friends, I do not share many other similarities with the participants of this study. The primary reason for my interest in this area may be traced to my background. In growing up, I was afforded the opportunity to have a significant amount of interaction with all four of my grandparents. In retrospect, I recognize the privilege I had in engaging in so much intergenerational contact. This seems to be less commonplace today.

During my mid-teen years, my paternal grandmother died as a result of cancer and eight years later, my maternal grandmother also died as a result of cancer. Reflecting on these memories, I realized that the majority of attention from myself and other family members was directed toward my grandmothers. My grandfathers spoke infrequently of their own experiences (which was consistent with their previous levels of self-disclosure) as they, in very different ways, cared for my grandmothers. The combination of my preoccupation with my grandmothers and my grandfathers' private deportment led to my curiosity concerning what their experiences were like.

Due to the influence of my grandparents on my life and my enjoyment in spending time with elderly people, I completed several undergraduate and graduate courses in gerontology. While in my master's program, I developed an interest in the effects of illness on spouse caregivers. In examining burden levels in relation to impairment of dementia patients, I included social support as a variable. I utilized a structured interview with paper and pencil instruments to assess these variables and was struck by the number of spouses who commented on how their relationships had been changed since the advent of their partner's dementia. Unfortunately, my measures were limited in scope and could not capture the dynamic social network fluidity that was being described by the spouses.

During my informative doctoral practicum at a local geriatric hospital, I became familiarized with interactions between elderly people and the health care system. Later, I was privileged to complete a one year internship in the Department of Psychology at the regional cancer treatment hospital. Throughout the year, I had the opportunity to work with patients of all ages as well as family members of patients. I was struck by how often family members seemed to be coping with greater difficulties than patients themselves and decided to explore the impact of disease further.

Another clinical observation gleaned during my internship was the difference in the number of adult men and women who availed themselves of psychological and other support services. Women outnumbered men by a wide margin, particularly in older age groups. I wondered, for example, if elderly men had sufficient interpersonal informal resources so as to reduce the need for formal support services. Or, were they unaware of the availability of such services? These questions and others were obviously difficult to address with elderly men directly because they did not present in the department.

I became more curious as to how elderly men experienced their wives' cancer and linked this with my interest in the social support process. I was also interested in how men experienced contact with health care workers devoted to the care of their wives. A literature review into the experiences of elderly husbands of cancer patients mirrored my experiences in the cancer hospital. Namely, little was known about these men.

The culmination of these personal, academic, and professional experiences led to the birth of the present study; an exploration of the relationships of elderly husbands of cancer patients from the perspectives of husbands themselves.

CHAPTER II: LITERATURE REVIEW

This chapter contains an overview of the literature pertaining to geriatric health issues and the psychosocial ramifications of cancer on family members. More specifically, experiences of elderly husbands of cancer patients are reviewed. The influence of social support on the well-being of husbands is discussed and followed by the presentation of the research questions used to guide this study.

Health Care and the Elderly Population

In his address of the challenges posed by an aging population on the Canadian health care system, Clark (1989a) examined issues surrounding financial allocations of health care dollars. He advocated increased funding of primary care and community-based services emphasizing quality of life that can be made available to many people in contrast to funding more costly "high-tech" services available to relatively few people. "Health-care policies, broadly interpreted, should add life to the years of the elderly, not simply years to their lives" (p. 135). While Gray, Doan, and Church (1990) commended the current trend to reduce the frequency and duration of inpatient care in favor of outpatient, community-based care, they expressed caution that funding for such services is not consistent across Canada and is at insufficient levels to ensure adequate community-based care. In a community-based health care system, family support of patients is ideally supplemented by services designed to enable the frail elderly person to avoid institutionalization for as long as possible. However, it is not uncommon for caregivers to require services themselves due to the burden associated with providing care to a person with chronic illness (Martens & Davies, 1990; Worcester, Archbold, Stewart, Montgomery, & O'Connor, 1990).

During the past decade, researchers have addressed the impact of frail elder health on the elder's family. Worcester and her colleagues (1990) attributed increased interest in this area to the convergence of three factors. First, the number of elderly people requiring care from families has increased dramatically. Second, illnesses are managed more effectively resulting in an extended time frame that family and formal health care providers give care. Improved treatment regimens and other factors have contributed to a shift in the epidemiology of diseases from acute to chronic diseases (Biegel et al., 1991).

Third, rising institutional health care costs lead to earlier discharges from acute care settings. An additional factor is related to the burden experienced by family caregivers secondary to their caregiving responsibilities (Gatz, Bengston, & Blum,1990).

Abel (1990) argued that the caregiving literature remains incomplete as the focus of these studies has been the quantification of two primary issues: caregiver chores and more predominantly, caregiver stress. This restricted focus has resulted in a limited understanding of the broader caregiving experience.

As more people are living longer with chronic illness and the Canadian population is progressively aging, it becomes paramount to understand the social and psychological ramifications of chronic diseases (Gerhardt, 1990). Gerontological studies of caregiving families have primarily concentrated on the demands placed on them by elders with dementia (Abel, 1990; Gatz et al., 1990; Hull,1990; Oberst, Thomas, Gass, & Ward, 1989). As a result, much less is known about the impact of other chronic diseases such as cancer. This is noteworthy as cancer incidence rates are much higher than those for dementia.

Cancer and the Family

It was estimated that in 1992, 115,000 Canadians were newly diagnosed with cancer. Further, it is projected that the number of Canadians diagnosed with cancer will increase by about 3000 annually and 1 in 3 Canadians will be diagnosed with some form of cancer (excluding non-melanoma skin cancer) in their lifetimes (National Cancer Institute of Canada, 1992). Cancer is more prevalent among elderly people than younger people as of 51,141 Canadian deaths attributed to cancer in 1989, 66% of males and 66% of females were over age 65 (National Cancer Institute of Canada, 1992). However, the elderly population has received considerably less attention than their younger counterparts (Baranovsky & Myers, 1986). Moreover, while the impact of cancer on patients has been well documented (Gray et al., 1990), the impact of the disease on family members is relatively less understood.

While advances in treating chronic illnesses such as cancer have led to lengthier prognoses, the prolongation of life does not necessarily translate into an enhanced quality of life for the people afflicted (Clark, 1989a) nor, by extension, to their loved ones as the impact of cancer extends far beyond those diagnosed (Pederson & Valanis, 1988; Sales, 1991; Zahlis & Shands, 1991).

Cassileth, Lusk, Strouse, Miller, Brown, and Cross (1985) found that anxiety, mood disturbance, and global mental health levels were significantly correlated for adult cancer patients and their family members. Further, patients and family members were affected by the patient's treatment status (follow-up care, active treatment, palliative therapy). Patient and family member well-being declined in accordance with the treatment progression. Adopting a systemic perspective, Northouse (1984) outlined how cancer impacts upon the entire family system as cancer patients both affect and are affected by family members. Parkes (1975) described the phenomenon in the following manner:

> Cancer invades a family in much the same way that it invades a human body. At first, locally, there are signs that all is not well but little general reaction ... as the diagnosis becomes more obvious there is a general mobilization of resources...sacrifices are made ... If the sacrifices pay off, he may recover, but if not there follows a period of deterioration when reserves of strength are used up, the patient's body grows thinner and weaker, and the family find that their reserves are also drained. (p.1271)

In examining the impact of cancer on family members, it is recognized that the cancer diagnosis marks the initiation of a process that can be divided into phases. Sales' (1991) review of the literature expanded upon Northouse's (1984) earlier description of initial, adaptation, and terminal phases. Sales documented the changing impact of cancer on the family through diagnosis, hospitalization, post-hospitalization, adjuvant therapy, recurrence, and terminal phases. It has been noted that the majority of family oriented studies have focused on the terminal phase (Biegel et al.,1991; Northouse,1984; Oberst et al.,1989; Sales,1991). Less research has been conducted on families of patients receiving non-palliative care (Carey, Oberst, McCubbin, & Hughes, 1991) or those who have completed treatment (Biegel et al.,1991).

Metastasis can occur at any time following diagnosis and is a very stressful time for patients and their families. Wellisch, Fawzy, Landsverk, Pasnau, and Wolcott (1983) compared families of patients with metastatic cancer to families of patients without metastatic cancer. The former had more impaired family relationships, felt more overwhelmed, and displayed greater mood disturbance.

Following a cancer diagnosis, patients and their families begin a journey into what for many is personally unchartered territory. On a personal level, uncertainty and a loss of control are inevitably involved as the cancer invades the body (Gray et al., 1990). Further, there are seemingly inflexible treatment regimens reflecting an imbalance of power which favors the health care system (Gray et al.,1990). Patients often report they feel like passive recipients of expert consultation. The result may be that formal and informal care providers foster dependency in patients and their spouses rather than encourage individuals to maintain as much independent functioning as possible (Clark, 1989b).

The provision of primary and adjuvant treatment on an ambulatory basis has become more commonplace with the development of outpatient treatments. Historically, patients receiving care as outpatients were considered to be well enough to require little care (Longman, Atwood, Sherman, Benedict, & Shang, 1992). However, ambulatory care today has greatly increased the demands on patients and their families to manage the cancer and side effects of treatment at home (Oberst et al., 1989). Cassileth and colleagues (1985) reported that family members of adult cancer patients receiving active treatment experienced decreased psychological well-being in comparison to family members of patients receiving follow-up routine checkups.

Despite the general recognition of cancer's impact on family members, the demands placed on them by adult cancer patients residing in the community has received relatively little attention in the literature (Oberst et al., 1989). Several authors have begun to address these shortcomings by identifying needs of family members. In addition to managing physical care, caregivers provide emotional support requiring considerable time and effort (Carey et al., 1991; Hinds, 1985; Oberst et al.,1989). Tringali (1986) observed that family members (9 of 25 were male and all members ranged in age from 22-71 years) of cancer patients most frequently cited informational needs followed by emotional needs. Physical needs ranked very low in importance. Hileman and Lackey (1990) interviewed cancer patients and their caregivers (93% were female and ages ranged from 29-68 years). They identified the following three need areas as most common: psychological, informational, and those related to household duties. Hinds (1985) interviewed family members of adult cancer patients receiving treatment and described the members as a group at risk with several unmet needs. They needed assistance with the physical care of patients and had unmet needs in psychosocial areas including assistance in dealing with their own fears and those of the patients. Longman and her colleagues (1992) interviewed cancer patients receiving outpatient treatment along with their caregivers (aged 19-79 years and 7 of 29 were male; relationships between caregivers and patients were not specified). The needs of patients and caregivers were assessed with both groups demonstrating considerable variation. Caregivers rated many patient "physical care" items as highly important to them despite the fact all patients were ambulatory. They also rated many items in the area of "involvement with health care" as very important. Included in this area were items such as "help obtaining physician orders", "need to be kept informed of patient's condition", and "assurance that patient can be admitted to a health facility, if needed". Individual caregivers reported that between 28% - 60% of the possible needs remained unmet by healthcare professionals or other resources. In sum, the above studies demonstrate that caregivers have diverse needs; needs that are often unmet.

Family focused care often implies that health professionals view the family or any subsystem thereof as a unit. Martens and Davies (1990) concurred with this principle but also recognized that the family unit cannot be viewed as a whole without considering the individuals who comprise the unit. These authors observed that spouses of cancer patients are particularly vulnerable as their devotion to their partners may preclude them from attending to their own health needs. However, spouses of cancer patients have been underrepresented in the literature despite increasing documentation that in general, spouses (if available and capable) are the main providers of assistance to post-hospitalized elderly married patients (Johnson, 1983) and noninstitutionalized married elderly people with illness (Cantor, 1983, 1992; Stone et al., 1987). Compared to other caregivers, spouses provide more hours of assistance and handle a broader range of tasks (Tennstedt, McKinlay, & Sullivan, 1989). Reductions in fertility rates combined with raising divorce rates lead to the greater likelihood that there will be fewer family members to care for increased numbers of elders in the future (Biegel et al., 1991). Further, the increasing numbers of women in the work force decreases their availability for assuming traditional roles as caregivers. As fewer daughters are available to provide care to an ailing parent, spouses would seem to be even more likely to shoulder the primary caregiving responsibilities in the future.

Cantor (1992) cautioned that the capacities of older couples in caregiving situations need to be considered. Concomitant with advancing age, many of these spouse caregivers may themselves be impaired. Therefore, they may be limited in terms of their abilities to provide some forms of assistance in daily living and will require assistance from informal and formal services.

Unfortunately, elderly caregivers have rarely been differentiated from their younger counterparts in the literature.

Carey and associates (1991) examined family caregivers (predominantly male and female spouses ranging in age from 23-76) of adult cancer patients receiving chemotherapy. Husbands reported spending more time and had greater difficulty with added household tasks and outside errands than wives of patients. More than half the caregivers received help from others, predominantly from family members. Martens and Davies (1990) interviewed seven advanced cancer patients and their spouses (four were husbands and all spouses were aged 44-68) in a qualitative study. They reported that spouses focused their "work" on what was best for the patients and applied their efforts to tasks associated with caring for their spouses. One dominant category of "work" was surviving which was described as "hanging on" or "carrying on" during their spouses' health deterioration. For all spouses, surviving included occupying their minds with other things and keeping physically busy with daily activities. Several spouses also described their jobs as a welcome diversion from providing care.

Hull's (1990) qualitative study examined the concerns and stress encountered by families (3 of 14 were elderly spouses) caring for terminally ill relatives within an oncology hospice home care program. Three general sources of stress were identified including patient symptoms, interactions with others, and concerns for themselves. Davies, Reimer, and Martens (1990) examined a similar sample and also utilized a qualitative methodology. They conceptualized the experiences of family members (including spouses aged 50-74; 5 of 8 were husbands) as a transition of "fading away." The transition began with an ending followed by a neutral zone and end point. The respective periods were characterized by the processes of redefining and dealing with burden; feelings of loneliness and fear, uncertainty, and confusion; and a new beginning where the focus of families was on living day-to-day and preparing for the patient's death. The authors noted that the realization that the patient was fading away was more clearly expressed by adult children and patients than by spouses.

Stetz (1987) interviewed spouses (32% of the 65 spouses were male; the mean age of all spouses was 66.4 years) of advanced cancer patients receiving services from a home-care agency. Advanced cancer was defined as cancer that had recurred at the original site or metastasized. All patients were receiving nursing care in the home. Male and female spouses reported that the dominant type of caregiving demand was managing the physical care, treatment regimen, and imposed changes. Managing the household and finances also posed a caregiving demand for slightly over half of the male caregivers. Another caregiving demand, labelled as "standing by," was evident in 42% of her sample of husbands. "Standing by" was described as observing the partner's experienced illness without reference to coping with the experience. An implied suggestion by this category was that spouses must cope with their inability to alter or manage their partner's illness.

Although the above studies examined the experiences of spouses, few distinguished between them on the basis of age or gender. Less is known about elderly husbands (Cantor, 1992; Gregory, Peters, & Cameron, 1990; Stone et al., 1987; Vinick, 1984; Zarit, Todd, & Zarit, 1986) despite the greater likelihood of husbands becoming caregivers in light of the demographical trends outlined previously. Further, husbands may be providing care for longer periods of time as five year cancer survival rates have increased for patients (Biegel et al., 1991). Following diagnosis, the five year relative survival rate is 45% for female patients aged 65 and over in contrast to 38% for similarly aged male patients (Baranovsky & Myers, 1986). Thus, following their wives' cancer diagnosis, elderly husbands have a strong likelihood of being impacted by their wives' cancer for several years.

That younger men are adversely affected by their partner's cancer was demonstrated by Zahlis and Shands (1991) in a sample of husbands of breast cancer patients. The men were aged 28-63 and therefore were faced with lifestyle adaptations not usually faced by elderly men (e.g., work schedule adjustments, child care arrangements). Northouse (1988) observed that husbands (the sample was not restricted to elderly males) of wives with breast cancer experienced similar levels of distress as their partners one month following surgery. In an earlier study, Northouse and Swain (1987) examined the experiences of 50 breast cancer patients and their husbands (aged 27-78) at two time periods, 1-6 days post-surgery and one month post-surgery. Many husbands reported feeling stress and exhaustion. They described difficulties in managing work and additional home responsibilities while offering support to their hospitalized wives. Males and females did not differ from each other in terms of overall mood state or levels of symptom distress at either time of measurement. Distress levels were significantly above those in the normal population. While improvements in mood state were observed one month post-surgery, levels of symptom distress remained consistent at both times of measurement.

In summary, most of the studies have focused on the terminal phase of cancer leaving gaps in the knowledge about prior stages. More specifically, awareness of metastasis prior to the terminal phase has rarely been examined in conjunction with family experiences. Further, while it has been recognized that the diagnosis of cancer has significant implications for family members as well as patients, caregiver samples have been heterogeneous. Studies have included a range of family relationships, both males and females with little or no differentiation between them, and different age cohorts. Elderly husbands have been included in samples but have rarely been differentiated from other family caregivers. In light of demographical trends, a shift toward community-based care, and increased cancer survival rates, it seems highly likely that more husbands will be providing care to wives diagnosed with cancer in the future. At least superficially, the experiences of elderly husbands would appear to differ from younger family members of cancer patients. For example, retirement precludes stress associated with employment (as well as the potential beneficial diversion from caregiving) and child care responsibilities are unlikely to be encountered. The greater potential of personal frail health would also differentiate elderly from younger spouses. Therefore, elderly husbands of cancer patients are the focus of the present study.

Relationships and Social Support

Abel (1990) cautioned that the tendency to quantify caregiving tasks and caregiver stress in studies of informal care for disabled elderly people has resulted in overlooking the fact that the chores do not exist in a vacuum. Instead, "they are embedded in intimate personal relationships" (p.141) and she advocated the importance of examining the complex web of relationships within which caregiving is embedded. In a 1992 editorial, Gottlieb outlined how the relationship context was often forgotten in the explosive interest in social support over the past two decades.

> Researchers concentrated exclusively on the provisions relayed by the network, distinguishing between emotional, tangible, and esteem support, and lost sight of the crucial fact that it was the very existence of a prior relationship which brought supportive meanings to interactions. Moreover, when support was removed from relationships, it came to be seen as a commodity that people exchanged rather than one among a

> large number of interpersonal processes that occur in the conduct of human relationships. (p.307)

Gottlieb's conclusions are relevant to the caregiving literature and consistent with Abel's criticisms. The relationship contexts of caregivers have received scant attention.

Conclusions drawn from the general social support literature are at times inconsistent and stem from varied operationalized definitions and measures of the construct (Heitzmann & Kaplan, 1988). In his review of the literature, O'Reilly (1988) concluded that there was a need for increased agreement on a conceptual definition of social support differentiating between social networks and social support. The former describes the structure of linkages between individuals and has a variety of functions including the provision of social support. The latter is indicated through the behavior of network members and communicated through the social network structure. Social networks of caregivers may include informal networks comprised of the patient, family, friends, and neighbors; and formal networks comprised of health care professionals and/or other people attending to patients and/or caregivers. Enacted social support is commonly categorized as tangible assistance, socializing, cognitive guidance, and emotional support (Cohen & Wills, 1985).

A further concern noted by Pagel, Erdly, and Becker (1987) is that researchers examining social networks have primarily focused on their positive aspects. This emphasis has resulted in glossing over "costs" which can also accrue in relationships. The costs may include "broken promises, network members who in the provision of support are irritating, annoying, or overinvolved, and help that comes with strings attached" (p.793). Indeed, these authors found that in their sample of spouse caregivers of patients with Alzheimer's Disease (caregivers aged 37-85 and 25 of 67 were male), the degree of upset with one's social network was consistently related to increased depression and reduced overall network satisfaction. The perceived helpful aspects of the caregiver's social network had little or no direct relation to these caregiver variables. Coyne, Wortman, and Lehman (1988) suggested that intended support attempts may go astray because recipients perceive them as untimely, excessive, or inappropriate. Thus, results suggest the importance of recognizing that social networks are not necessarily supportive all of the time.

The majority of caregivers in Nugent's study (1988) experienced changes in their social network since assuming their caregiving roles, whether an increase or decrease in the amount of support offered by others as reflected in the number of visits and contact with network members. This fluctuation in social networks and their inherent fluidity has rarely been captured in the literature. Most social support research has been cross-sectional with little accountability of the dynamic qualities of networks. As noted by the caregivers in Nugent's study and voiced previously by George and Gwyther (1986), networks may mobilize at some times and dissipate at others. Some authors such as Gottlieb (1983; 1992) have conceptualized social support as a dynamic process. He observed that in past research, social support "gained the status of a variable that could be measured in terms of a fixed quantity and relative quality when it should have been seen as a process that is dynamic and subject to a complex set of contingencies that influence social interaction" (1992, p.307). Cross-sectional assessment has been unable to capture the process accordingly. The process from the recipient's perspective has not been illuminated in the literature.

Social support and cancer. While social support has received considerable recognition as a factor affecting the coping ability of cancer patients (Dunkel-Schetter, 1984; Rose, 1990), social support for caregivers has rarely been examined (Biegel et al., 1991). There is limited evidence of the positive effects of social support on husbands of cancer patients. Northouse (1988) sampled breast cancer patients and their husbands (aged 27-78; wives underwent mastectomies one month previously) in her study of adjustment to breast cancer. Psychosocial adjustment was viewed multidimensionally, composed of a positive balance of mood states; absence of extreme psychiatric distress; and ability to function in work, family, and social roles. Patients and husbands receiving higher levels of support had fewer psychosocial adjustment difficulties than patients and husbands receiving lower levels. Further, continuing to receive support (30 days post surgery) was more important than initial support (3 days post surgery) in determining the husbands' later adjustment. Husbands and wives perceived similar amounts of support from their spouses and family members immediately following the surgery. At the same time, husbands reported significantly less support than wives from friends and formal sources. One month later, the same results surfaced.

Hileman and Lackey (1990) reported that their predominantly middle-aged female sample of caregivers of patients voiced a large number of essential needs pertaining to social ties with family and friends. Qualitative data reflected needs of caregivers for support from families and friends. The absence of outside support for patients create additional stress on family members who fulfill the supportive role. However, the opposite may occur when a patient relies too heavily on outside support as the spouse may feel like an outsider (Pederson & Valanis, 1988).

Most research in this field has described sources of support. Oberst and her colleagues (1989) examined a sample of 47 family caregivers (aged 25-74; 77% female) of adult cancer patients undergoing radiation therapy. Just over one third of the family members had no assistance with giving care. Of those that received assistance, the majority reported that they received it from family and friends. Less was received from health care professionals. This pattern has also been documented by others. Martens and Davies (1990) reported that predominantly middle-aged male and female spouses of advanced cancer patients identified internal and external resources enabling them to cope with their situations. In reference to the latter, health care professionals mainly provided disease-related information. More significant interpersonal resources consisted of family and friends. Hinds (1985) observed that families sought assistance for social and emotional needs with most support derived from informal social network members such as relatives and friends; little support came from formal health care providers. Similarly, husbands perceived significantly less support from health care professionals than patients in Northouse's study (1988) and consequently felt distanced from the health care system. Nugent (1988) observed that families of terminally ill cancer patients remaining at home placed a burden on the caregivers that was modified by the support of other people. Most support came from the primary group including the family member's spouse, family, friends, and neighbors.

One study suggested a different pattern of network interaction with formal and informal members. Vinick (1984), in her retrospective study of elderly widowers, reported that the men mentioned they had received considerable support from home care nurses but seldom discussed support from others. She asked (p.67), "Is this a function of the relative inexpressiveness of men, do they fail to perceive the support of others, or is such support not forthcoming?" Answers to such questions are important in order to determine the influences of informal as well as formal relationships in the lives of men caring for their spouses. The answers may be more accessible with men in the midst of the caregiving situation rather than through retrospective responses.

In the marital relationship, spouses and cancer patients appear to have different experiences in reference to social support. Whereas advanced cancer patients in Martens and Davies' study (1990) reported that their main resources came from within themselves, spouses relied more on outside support. Patients indicated they received sufficient support from their spouses but spouses expressed a greater need for contact with others. Vinokur and Vinokur-Kaplan (1990) described a general pattern of breast cancer patients (aged 43 - 85) providing more social support to their husbands than they received from them. However, with more seriously ill patients, husbands provided somewhat more social support than they received, presumably responding to the recency of their spouse's treatments. At the very least, an elder's health decline generates increased dependency and a need for assistance (Gatz et al., 1990) that creates changes in the marital relationship. Carey and colleagues (1991) reported that in their sample of family caregivers of adult cancer patients receiving chemotherapy, the patient's increased dependency was the main contributor to caregiving burden.

It is important to note that cancer patients are not merely recipients of support, they can also provide support to their spouses. There has been a tendency to ignore such contributions and instead, solely portray patients as passive support recipients. Abel (1990) contended that the description of supportive actions has typically been the focus while interactions have received little attention. Consequently, the relationships between spouses has not been explored in the fullest context; that is, within the framework of reciprocal interactions.

Social support and dementia. The more extensive literature based on caregivers of dementia patients has addressed concepts in addition to the identification of support sources which has dominated the literature on caregivers of cancer patients. While it is uncertain how generalizable these results are to cancer patient caregivers, the following studies raise potential issues for this population. Miller (1987) interviewed 15 elderly husbands and wives of cognitively impaired elderly spouses to explore if they emphasized different dimensions of control in four areas including one that is most relevant here: the use of social support. Husband and wife caregivers received emotional support but little concrete help from adult children. All spouses indicated their relationships with friends were curtailed due to increasing caregiving responsibilities. Moreover, others saw them as two individuals - one impaired and one healthy - rather than as couples. Caregiving husbands and wives differed in their solutions to the curtailment however. Whereas wives tended to participate in support groups for caregivers, husbands generally believed they received greater benefit from pursuing free-time interests unrelated to their family situation. Husbands claimed it was too upsetting to hear of other difficulties associated with Alzheimers Disease. "Men stressed continuity in the environment for those aspects of it under their control such as their involvement in household projects and non-attendance at support group meetings. In this way, they selectively ignored some of the uncertainty they experienced as caregivers" (p.452).

Advanced cognitive deterioration of dementia patients is evident far less frequently in cancer patients. This difference may account for some of the contrasts between Millers' study and those discussed previously. Further, cancer patients may be more physically impaired and therefore require more outside assistance.

Millers' (1987) results suggest husbands may pursue greater autonomy than wives of partners with dementia. Barusch (1988) also interviewed spouse caregivers (aged 55-89 with 35% of the 89 participants males) of partners suffering predominantly from dementia. Male and female spouses were not differentiated in the data analysis. The most common coping response to caregiving demands was to seek help from family or professionals. Of a group of specific coping techniques, most spouses preferred to change their situation through their own efforts or with help. Barusch identified a reluctance by a number of caregivers to seek or accept assistance and attributed this to a preference for personal control. Unfortunately, it was unclear whether the caregivers' reluctance was in reference to accepting only formal assistance or a combination of informal and formal assistance. Nevertheless, these results seem to be consistent with Millers' (1987) in suggesting the importance of addressing the caregivers' perceptions of accepting support. There are health care ramifications as "programs designed to increase caregivers' use of services and social support may run counter to caregivers' preference for personal control" (Barusch, 1988, p.684).

In general, research has documented that the extent to which elderly individuals take control over their lives and health determines in a major way their level of well-being (Clark,1989b). Rodin (1986) reviewed evidence suggesting that the strength of the relationship between a sense of control and health increases with age although variability in preferred amounts of control also increases with age. Clark cautioned that an increased focus on the "positive effects of a sense of control over one's life should not be interpreted as an endorsement of the view that successful aging must entail total independence and lack of reliance on the support of others" (1988, p.280). Every human being is dependent on others to some degree. Clark (1988) addressed this issue from the perspective of nursing home implications but it appears to be applicable to community care as well. An emphasis on autonomy for elderly people can draw attention from the need for interconnectedness and interdependence.

Aside from references to control in the above studies, there is a dearth of information pertaining to how husbands experience their relationships with people. Therefore, in the present study, the perspectives of elderly men on their personal relationships are addressed.

Research Questions

The importance of including the experiences of cancer patient families to better understand the ramifications of this disease has been well established. However, the literature has primarily focused on the practical struggles faced by families and has virtually excluded elderly spouses. More specifically, the experiences of elderly husbands following their spouses' metastasized cancer prior to the terminal phase have not been explored. This study explored the dynamic nature of their relationships in-depth from their own perspectives. No hypotheses were tested. Rather, hypotheses were to be generated. My intent was to explore the relationships that elderly men had with their wives, family, friends, and wives' health care personnel.

Research questions at the initial stages of a qualitative study into a relatively untapped area serve as guidelines rather than tightly-framed preconceived hypotheses. Questions are expected to evolve as the study progresses, depending on data arising from the participants. The general question guiding the study is simply:

1. What is the nature of the network relationships of elderly husbands of wives with metastatic cancer?

Related general questions included the following:

2. Do husbands receive assistance and if so, from whom and what forms of assistance?
3. What are the psychological, behavioral, physical, and emotional consequences of their interactions with health care professionals and informal social network members such as their spouse, family, friends, and neighbors?
4. Does the nature of their interactions change over the course of their partners' illness?
5. How are decisions to request and/or accept/reject offers of assistance reached?

CHAPTER III: METHODOLOGY

In previous studies, family members of patients have typically responded to inventories designed by researchers based on literature reviews and consultations with health care professionals. Consequently, our understanding of the family caregiving experience has been predicated on devised constructs (Thorne, 1985) as items on such measures have rarely been generated directly from family experiences (Hull, 1990). The perspectives of those most involved therefore remains a relatively untapped resource. There is a need for the husbands' experiences to be documented in a manner unbiased by the limitations of preconceived instruments. Furthermore, the research in this area has typically been cross-sectional. Cross-sectional designs are limited in their capacity to capture the dynamic nature of experiences over time (Hull, 1990) and consequently, limit the understanding of the full nature of husbands' interactions within relationships. The primary goal of this study was to understand the experiences of husbands from their own perspectives. Therefore, the methodology was qualitative in nature.

Qualitative research methodology is introduced below and is followed by a description of the specific type of qualitative research employed in the present study - grounded theory. The implementation of the study is then presented and followed by a discussion of the present study's trustworthiness.

Qualitative Research

Strauss and Corbin (1990) described qualitative research as "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (p.17). Qualitative methodology is best suited for understanding what lies behind the phenomenon of something that is little understood and for examining the experience in-depth from the perspectives of those experiencing the investigated phenomenon. "Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 1994, p.2).

Terminology differs in qualitative and quantitative research. While the rigors of sound and good science are retained, the canons require redefinition to fit the realities of the complexities of social phenomena addressed by qualitative research (Strauss & Corbin, 1990). Sandelowski (1986) constructed a framework for the purpose of understanding similarities and differences in the two approaches. The framework is comprised of four factors pertinent to addressing the rigors of quantitative and qualitative research. The factors, based on Guba and Lincoln's work (1981), include truth value, applicability, consistency, and neutrality. Guba (1981) identified these factors as aspects of research trustworthiness.

The first factor, truth value, is evidenced in qualitative inquiries through the discovery of phenomena as they are lived and perceived by respondents (Sandelowski, 1986). This is contrasted with the quantitative research focus on verification of a priori conceptions of the experiences. Thus, in qualitative approaches, "truth" is not defined by the researcher but rather, is participant-oriented. Credibility, rather than internal validity as defined in quantitative research, is the criterion against which to evaluate the truth value of qualitative research. Credibility is established when the results can be recognized by other people having the investigated experience as consistent with their own experience.

In establishing applicability in qualitative research, fittingness is the criterion. Fittingness occurs when results "fit" the data from which they were derived and further, when they can "fit" into contexts removed from the research situation and when readers view the results as meaningful in relation to their own experiences. "Findings are well-grounded in the life experiences studied and reflect their typical and atypical elements" (Sandelowski, 1986, p.32). Fittingness approximates the concept of external validity in quantitative research which refers to generalizability of results and the representativeness of samples, measures, and testing situations. Quantitative studies are tightly controlled in the quest for generalizability and representativeness. In contrast, qualitative research emphasizes the study of phenomena in natural environments and with few controlling conditions. Quantitative research typically employs conventions of statistically based sampling procedures to ensure generalizability and representativeness. The relatively small size of qualitative study samples is attributable to the focus on in-depth analysis. Samples in qualitative studies are also selected purposefully (Patton, 1990) as information-rich cases are sought in order to learn a great deal about issues of central importance to the purpose of the study. "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researchers than with sample size" (p.185). Respondents are initially selected because of their abilities to articulate the phenomenon under investigation. As the study progresses, the continued selection of participants is dependent upon the emerging results. Representativeness in qualitative research refers to the data rather than subjects or settings.

The third factor, consistency, approximates reliability in quantitative research. Qualitative research emphasizes the uniqueness of human situations. Variations in experiences are sought. Further, phenomena in qualitative studies are not necessarily restricted to experiences that can be validated through the senses as is typical of quantitative studies. The criterion for consistency in qualitative research is auditability which occurs when another researcher can follow the trail of decisions made by the investigator. Given the investigator's data, perspective, and situation, another researcher should arrive at similar conclusions as the study's investigator.

Finally, the factor of neutrality is evidenced when the research process and product is demonstrated to be as free as possible from bias. It is recognized that no study is entirely free of bias. Objectivity is the criterion of neutrality in quantitative research and is addressed through the establishment of reliability and validity. Whereas quantitative researchers typically strive to maintain distance between themselves and their subjects and data, qualitative researchers reduce the distances by eliminating artificial boundaries between the subjective and objective. The naturalistic paradigm asserts that the researcher and respondents are interrelated (Guba, 1981). "Engagement with rather than detachment from the things to be known is sought in the interests of truth" (Sandelowski, 1986, p.34). In qualitative investigations, confirmability formulates the criterion for neutrality. Confirmability is evident when the truth value, applicability, and consistency factors are established. Confirmability therefore refers to the results rather than to the investigator's subjectivity or objectivity.

Many methodologies fall under the rubric of qualitative research. Grounded theory was selected for the present study as it best addressed its purpose. The objective of grounded theory methodology is to develop theory that explains basic patterns commonly occurring in social life (Chenitz & Swanson, 1986). Grounded theory is well suited for examining phenomena which have received little study and to discover what participants themselves see as problematic and how they resolve the issues (Stern, 1985). In the present study, the focus was on the relationships of husbands of cancer patients - from the perspectives of the husbands themselves.

Grounded Theory

This brief description of grounded theory is supplemented by later sections describing the data collection and data analysis procedures. The intent here is to provide some background information about grounded theory and describe the product of this form of research.

Grounded theory was originated by two sociologists - Barney Glaser and Anselm Strauss. This methodology was first presented in 1967 (Glaser and Strauss) and developed further by Glaser in 1978. Both authors contributed further monographs with the most recent in 1992 (Glaser) and 1990 (Strauss & Corbin). In his 1992 monograph, Glaser forcefully expressed his opinion that his co-originator strayed from their original conceptualization of grounded theory. Glaser refuted the 1990 work of Strauss and Corbin on several grounds. It is beyond the scope of this dissertation to fully account for his arguments but in brief, Glaser branded Strauss' 1990 work as a means to obtain full conceptual description rather than grounded theory. In Glaser's opinion, Strauss shifted toward a forced and preconceived methodology in contrast to grounded theory where the social psychological organization of those studied is allowed to emerge from their own perspectives.

In reading the latter works of the two co-originators and comparing them to the 1967 and 1978 publications, I decided to align my methodology with Glaser's description of grounded theory. To me, the 1978 and 1992 accounts are more consistent with the first description (Glaser & Strauss, 1967). Therefore, I relied primarily on the 1967 description and Glaser's 1978 work to guide the methodology for this study.

What is grounded theory? To put grounded theory in historical perspective, it is necessary to acknowledge its roots in the symbolic interaction tradition of social psychology and sociology (Becker, 1993; Blumer, 1969; Chenitz & Swanson, 1986). This tradition "focuses on the meaning of events to people in natural or everyday settings" (Chenitz & Swanson, 1986, p.4). Allied with phenomenology, both principles examine "how people define events or reality and how they act in relation to their beliefs" (p.4). Meanings of situations are created by people and lead to actions and consequences of those actions. Reflecting this tradition, grounded theory provides a means to examine behavior and interactions. It produces abstract concepts and hypotheses about the relationships between them.

As alluded to earlier, grounded theory focuses on the perspectives of those participating in the study. The researcher analyzes the participants' experiences with the purpose of "generating concepts and their relationships that explain, account for and interpret the variation in behavior in substantive area under study, which behavior is most often hinged around processing a problem for the subjects" (Glaser, 1992, p.19). Thus, the researcher identifies an area of study without forming a priori hypotheses. The researcher remains open to discovering the respondents' problem and the process by which they attempt to resolve it.

Grounded theory systematically links the data collection with data analysis in a cyclical manner whereby analysis leads to further data collection, in turn leading to further analysis, etc. until such time that the inductive theory is saturated; that is, until data collection does not yield further concepts in the substantive area. The end result of a grounded theory is a product that "constitutes a theoretical formulation or integrated set of conceptual hypotheses about the substantive area under study" (Glaser, 1992, p.16). Grounded theory methodology generates theory comprised of integrated hypotheses. Hypothesis verification or testing utilizes different research methodology (e.g., experimentation) and therefore, goes beyond the purpose of grounded theory. Grounded theory moves beyond a descriptive mode as it represents a discovery mode (Becker, 1993). While these modes have similarities, the latter uses description as a means to an end: "The end is to answer the questions, 'What is going on and how?" (p. 255). These questions are answered by the construction of a theory regarding the investigated phenomena.

A major strength of grounded theory is its open-endedness and flexibility as data collection and analysis occur simultaneously (Charmaz, 1990). This permits the researcher to follow-up on ideas and emerging themes as the research progresses. Throughout the data analysis, the research questions undergo further refinement and specification.

Grounded theory is particularly applicable to identifying and rendering processual analysis (Charmaz, 1990). As discussed previously, most of the social support literature is based on cross-sectional designs that are limited in terms of addressing the dynamic qualities of social network interactions and the experiences of the recipient. "Process" refers to the linking of sequences of action/interaction as they pertain to a phenomenon. The process component provides a sense of the flow of events occurring with the passage of time. It is a means to account for or explain change. However, process (like all other theoretical codes), should not be forced on to the data by the researcher. Process is one of 18 theoretical codes identified by Glaser (1978) to connect emergent categories. He cautioned that like all other codes, it will emerge in the data if it is relevant (Glaser, 1992).

Grounded theory is generalizable to the specified situations in terms of concepts. Generalizability is "measured by the applicability of our concepts to other samples, settings, and situations" (Conrad, 1990, p.1259). If the theory does not account for variation discovered in subsequent research, the discovered specificities can be added as amendments to the original theory. "Theory based on data can usually not be completely refuted by more data or replaced by another theory. Since it is too intimately linked to data, it is destined to last despite its inevitable modification and reformulation" (Glaser & Strauss, 1967, p.4).

A well constructed grounded theory has four criteria (Glaser, 1992). First, participants, practitioners, and area researchers will detect a "fit" with the substantive area studied. Second, if the theory "works," it will explain behavioral variations in the area in regard to how participants process their main concerns. If the grounded theory both fits and works, it has achieved "relevance." Finally, the theory should be readily "modifiable" in view of new data. When variations in categories emerge, the theory is not verified nor discarded. Rather, it is modified to accommodate the information as the new concepts are integrated.

Implementation of the Study

Participant Eligibility Criteria

Eligible participants for this study possessed the following characteristics: at least 65 years of age; retired; married to a spouse diagnosed with metastatic cancer who, as best could be determined by medical staff, was not terminally ill at the time of the first interview; resided with spouse in a community-based environment (i.e., not residents of a nursing home); willing to discuss their situation; able to articulate experiences clearly; able to speak and understand English fluently; residents of the same city as the researcher (a large western Canadian city) or immediate surrounding area (within one hour drive).

The eligibility criteria were established in light of the relative absence of research on elderly husbands of cancer patients and other considerations. The 65 year age cutoff was somewhat arbitrarily chosen but based on traditional social definitions of entry into the 'elderly' population (e.g., receipt of government pension). The retirement criterion was selected because employment would seem to introduce different dynamics into relationships - marriages as well as others. The criteria for marriage to a spouse with metastatic cancer reflected the absence of information regarding this stage of cancer. Wives who were non-terminally ill were sought because of the longitudinal aspect of the study and the hope that attrition could be kept to a minimum. Furthermore, there is considerably more attention in the literature given to terminally ill patients and their families. Residence in the community was a criterion because institutional residence carries far greater exposure to the health care system and is likely to alter existing friendships and other relationships. With the emphasis on interviewing as a means to collect data, potential participants needed to be willing to describe their experiences and have the ability to articulate their experiences clearly. As English is the only language spoken by me, the criteria for English speaking participants was apparent. Finally, participants were sought within a one hour radius of the western Canadian city where I reside as it was hoped that this step would open up the possibility of including rural participants, thereby diversifying the sample.

Procedure

The local chapter of the Canadian Cancer Society, a local hospital, and the regional cancer care institute were contacted to determine their interest in participating in the study. All three organizations authorized the study to proceed following deliberations of their internal ethics review committees.

The directors of the local chapter of the Canadian Cancer Society expressed interest in the study as they had traditionally experienced a paucity of male participation in their programs, particularly amongst elderly husbands of cancer patients. An Information Sheet (Appendix A) containing my name and telephone number, eligibility criteria, and purpose and description of the study, was constructed for posting in appropriate locations. However, given that few eligible husbands frequented the offices, personnel decided to personally contact men identified by them as potential participants. To ensure confidentiality, Society personnel contacted potential participants and explained the nature of the study. Personnel assured any person contacted in regard to the study that the provision of programs received by anyone connected to him would not be affected by his participation decision. If interested in participating, husbands were given the option of contacting me directly or giving their consent for the staff person to provide me with their name and telephone number. In their record review, personnel identified one husband as a potential participant. Upon contact with me, he consented to participate and signed the Consent Form (Appendix B).

The local hospital contacted about the study contained a palliative care unit but referrals to it were not eligible for participation in this study. It was hoped that husbands of non-palliative care patients could have been identified apart from this program but this proved too unwieldy. Subsequently, no husbands were accrued from this hospital.

The remaining seven participating husbands were accrued at the regional comprehensive care cancer treatment and research centre. At the Institute, oncological services are provided to inpatients and outpatients as well as their families. In accordance with the provincial cancer board ethics review committee policy, staff did not contact potential participants about the study. It was preferred that I speak to potential participants as it was thought that husbands who were approached in this way would feel less coerced to volunteer for the study. The committee believed that if someone external to the Institute requested their participation (as opposed to a staff person), husbands would feel freer to turn down the request.

Female patients with metastatic cancer are seen in weekly clinics at the Institute. Some are in active treatment whereas others attend appointments at varied follow-up intervals, dependent upon their health status. The clinic coordinator nurses are provided lists of patients to be seen during each clinic. I reviewed the lists with the coordinators (and on occasion with clinic doctors) to determine if there were potential participants as determined by the eligibility criteria. Widows, divorced, and other single women were easily identifiable by information on the lists and patient charts. They were subsequently excluded. The clinic coordinators and physicians familiar with the patients' prognosis excluded those that were near death or receiving palliative care. Clinic coordinators also excluded those who they knew to speak a language other than English. On the basis of the patients' address, patients were excluded if they lived beyond an hour's drive from the city of the cancer clinic. The age of husbands was not verifiable on the clinic lists or patient charts. Therefore, patients over the age of 55 were identified as it was reasoned that they could have married men several years their senior. Women under age 55 were excluded.

Based on these preliminary inclusion procedures, the names of potential participants were derived. The men were then approached personally by me if they had accompanied their wives to the hospital or were telephoned if they had not. During this initial contact, I introduced myself and briefly explained the purpose of my study following the format contained in the Information Sheet (Appendix A). If interested in volunteering to participate, the remaining eligibility criteria were ascertained (age, retirement/employment status, co-residence, and community residence). Providing the inclusion criteria were met, the participation requirements were outlined. A Consent Form (Appendix C) was then provided (directly if I met with them personally or mailed if otherwise) and men were informed that I would contact them within a few days to clarify any questions. As per provincial cancer board requirements, the Consent Form contained information pertaining to the purpose of the study and specific participation requirements. Their rights to confidentiality and withdrawal from the study were also clearly described. My name and number as well as the Psychology Department director's name and number were also included.

In total, 23 men were approached on the basis of preliminary eligibility criteria ascertained from patient files and staff information. Of these, one was currently employed and seven were younger than 65. One was too ill, another was embarking on an extended vacation, and one man felt he was too busy to spare the time. One husband stated he would feel too uncomfortable, not knowing what to say in an interview. Four stated they were not interested in participating for unspecified reasons. One husband indicated his interest in the project but felt he could ill afford the time to participate for the duration of the study. However, he consented to read the draft of the findings and comment on the degree to which it "fit" his experiences. Seven men agreed to participate and Table 3.1 contains demographical data about each husband (pseudonyms). Interviewing took place between January, 1993 and June, 1994.

Within a few days of their receipt of the Consent Form, the potential participants were contacted and any questions about participating in the study were answered. If the men expressed a willingness to participate, an interview was scheduled in the location of their choice. Five of the men were interviewed in their own homes, two were interviewed at the Institute while their wives

Table 3.1 Participant Descriptions

Partici-pant	Age	Retired	Former Employ.	Husband Health	Years Married	Children (Local)	Wife's Age	Diagnosis (mets)	Diag. Date (mets)
Art	67	7 years	profess-ional	good	40	4 (4)	62	breast (brain)	1992 (1994)
Bob	71	7 years	service industry	fair	45	6 (6)	70	breast (bone)	1986 (1990)
Ed	65	2 years	construc-tion	good	40	1 (1)	65	bone mar-row(bone)	1990 (1991)
Joe	68	4 years	service industry	fair	44	7 (3)	69	breast (lung)	1991 (1992)
Martin	66	1 year	trade	excellent	41	4 (3)	68	breast (bone)	1985 (1990)
Paul	69	5 years	transpor-tation	excellent	40	0	60	breast (liver)	1975 (1992)
Roy	68	7 years	profess-ional	fair	42	4 (3)	68	breast (bone)	1970 (1992)
Tom	72	9 years	transpor-tation	fair	44	3 (3)	65	breast (lung)	1983 (1993)

received treatment, and one husband was interviewed in his home on one occasion and in the Institute on another occasion.

Upon meeting with the husbands, the Consent Form was reviewed and if necessary, clarification was provided. Two copies of the Consent Form were signed, one of which was kept by participants for future reference. Interviews were unstructured in order to enable respondents to describe personal experiences in their own ways. (A more complete description of the interview format follows.) Initial interview lengths ranged from 45 - 95 minutes.

Interviews were audio-tape recorded and transcribed. The transcriptions were then mailed to husbands who were requested to verify the accuracy and further, to clarify or add comments regarding their experiences. Most husbands returned their transcripts without changes to them. The three husbands that altered transcripts focused on grammatical changes (e.g., stroking out repeated words and 'ums') or removed possible identifying information (e.g., holiday locations, previous employers).

Conrad (1990) observed that in recognizing chronic illness as a process, it would be most useful to conduct multiple interviews over a period of time as this strategy avoids reliance on memories and retrospective interpretations of respondents. Participants in the present study were followed up 8-12 weeks after the first interview. The purpose of the second interview was first, to encourage participants to describe subsequent experiences and second, to pose questions pertaining to specific categories based on preceding data analysis. Second interviews afforded an opportunity to document any changes in relationships following the first interview. In the second interview, the prior interview transcript was reviewed and husbands then provided additional information subsequent to our first meeting. The recorded interviews were then transcribed and mailed to respondents as previously. Second interviews were shorter than first interviews, ranging from 30 - 60 minutes.

In light of unexpected and rapid deterioration of their wives health, I was unable to re-interview two husbands before their wives' deaths. The husbands were understandably preoccupied with their wives during the health declines and were hesitant to be reinterviewed under the stressful circumstances. The wife of another husband died suddenly of a heart attack four months subsequent to our second interview.

As the wives' health status emerged as an important consideration in participants' relationships, the three widowers were approached 7-9 months after their wives' deaths to determine their willingness to discuss their relationships spanning the time between our last interview and their wives' death. One participant indicated that the memories of his wife were still too fresh and feared that further discussion would be too painful. This husband was not interviewed a second time. The other two participants consented to relate their experiences. One was interviewed for the second time while the other participant was interviewed for the third time in total. Both provided pertinent information about their relationship experiences prior to their wives' deaths. Many experiences following their wives' deaths were also relayed but the information was not included in the analysis as it reflected bereavement issues and was beyond the scope of this study.

The data were analyzed using the constant comparative method (Glaser, 1978; 1992) which is described in detail later. Emerging codes from ongoing data analysis were synthesized and sent to husbands for feedback. Aside from a few demographical errors (e.g., length of diagnosis), husbands indicated their approval of the codes and categories.

Following data analysis and the subsequent write-up of the results (i.e., Chapter IV), the resulting theory was provided to each husband. This occurred an average of four months following their last interview. This elapsed time added to the longitudinal aspect of the study as participants were encouraged to note any changes in their relationships since we had last met. Further, participants were requested to review the theory and determine how it "fit" their own experiences. Husbands were encouraged to provide any feedback that could be helpful to better understand their experiences. One of the widowed participants declined to offer feedback on the results due to his concern that to do so could dredge up painful memories. Another husband's wife was hospitalized at the time of review and therefore, he declined to read the draft. The other six participants reviewed the theory and provided feedback.

In addition to the eight participants, another husband fitting the eligibility criteria was identified and requested to review the theory to indicate how accurately it reflected his experiences. His comments as well as those of the participants were incorporated into the theory.

I wrote field notes recording observations and other descriptive data immediately following each interview to ensure accuracy and thoroughness.

Memos regarding analytic thinking and the decision-making process were also maintained during interviewing and analysis of the data. This process will be explained in greater detail below.

Confidentiality was respected at all times. The names of respondents did not appear on any transcribed interview as pseudonyms were selected by participants or provided by the researcher. Other identifying information such as names and places were also removed from transcripts. All tapes and interviews were stored in a locked cabinet and at the completion of the study, tapes were erased. As reviewed in the Consent Form, participants were also aware of their right to withdraw at any time and to refuse to answer any question. In regard to the latter, one husband spoke of his concerns about his wife's potential death but reconsidered and asked that his statements be removed out of his concern that his wife may see the comments on his copy of the transcript. I obliged.

Interviewing procedure. When interviewing, it is important that the researcher establish rapport with participants while not undermining neutrality. Patton (1990) provided a description of researcher rapport and neutrality. The former implies respect of the people being interviewed while conveying to them that their experiences are important. The latter implies that the researcher will not judge the participants for the content of what they divulge. While these guidelines are imperative in any interviewing situation, they were paramount in this study because of the novelty to participants of being interviewed and being involved in a research project.

I was sensitive to any mental health issues arising during interviews. I am a chartered psychologist and was prepared to refer participants to appropriate services if necessary. None of the husbands required such a referral.

In order to develop rapport and engage the participant, Charmaz (1990) suggested that initial interview questions be comprised of short face-sheet types before moving towards more informational, reflective and feeling, and ending questions.

Short face-sheet questions are neutral and limited to necessary factual information. Conversely, Patton (1990) suggested that background and demographic questions be spaced strategically and throughout the interview rather than lumped together at the beginning of the interview. His reasoning follows from the need for respondents to become actively involved in providing descriptive information as soon as possible. Demographic questions at the onset of the interview could potentially condition respondents to providing short answers and more routine responses. Therefore, in this study, demographical data was collected throughout the interview as appropriate. Overlooked information was garnered at the conclusion of the interview. To ensure thoroughness and consistent background information gathering on all participants, a Guideline (Appendix D) was used. The Guideline included the spouse's and patient's age, education, and employment background; the couple's length of marriage; the number of children and their residence proximity; the patient's diagnosis and date of diagnosis; treatment history; prognosis (if known); and the husband's estimation of his personal health.

Informational questions (Charmaz, 1990) establish chronology, types of events that have occurred, other people involved in the situation, etc., while drawing the participant further into the interview. These non-threatening questions enable further development of rapport. In the present study, informational questions were asked following completion of the Consent Form and after all of the participants' questions were answered. This step provided participants with the context and general purpose of the interview. The opening informational question in this study was, "Please describe your relationship experiences since your wife's cancer diagnosis." Within this context, participants were asked to expand on the nature of their relationships. If participants did not mention at least one member of the social network at large (i.e., family, friends, neighbors, wife's health care personnel), they were questioned specifically about potential contact. As the participants described the composition of their formal and informal social networks and interactions with the members, further information was ascertained through the use of reflective questions.

Informational questions encourage the person to talk descriptively (Patton, 1990) and provide the basis for reflective and feeling questions (Charmaz, 1990). Reflective questions pertained to direct issues concerning the husbands' experience. For example, questions such as, "How did your friends' invitation to dinner affect you?", or "How did you see yourself then?", provided further information about the participants and their relationships. Questions pertaining to affect provided further information but as they were usually of a more sensitive nature, such questions were asked later in the interviews pending the comfort levels of the participants. Finally, ending questions were designed to complete the interview on a positive note in addition to eliciting further information.

To summarize the interviewing procedure, interviews were unstructured and the following guidelines were operative during the study. Upon meeting with participants, I reviewed the study and ensured that the Consent Form was understood and signed by the participants. In order to establish rapport, participants were asked informational questions thereby establishing the past and current context of their caregiving experiences. Participants described their relationships with social network members and probing questions of a reflective, affective, and ending nature were asked to illuminate their experiences further. Background information was also gathered throughout the interview.

It should be noted that in keeping with grounded theory methodology, initial interviews were less structured than those conducted near the completion of the study. Subsequent interview questions also became more structured and refined as the research progressed and the data were analyzed. In this manner, further specific details pertaining to emerging categories were garnered while remaining open to new, previously uncoded phenomena.

During initial interviewing of the first two participants, the main focus was to generate as many categories as possible because the emphasis in the early stages of qualitative research is exploratory (Patton, 1990). Later, the focus became further development and saturation of categories. In grounded theory, theoretical sampling is a tool to achieve this end. The aim of theoretical sampling is to sample events and incidents that are indicative of categories so that they can be further developed and conceptually related. Patton (1990) refers to these later research stages as confirmatory fieldwork as the viability of emerging results are checked out with new data and confirming as well as disconfirming cases. The latter are examples that do not fit and can serve as a way of placing boundaries around confirmed results.

The practice of theoretical sampling presumes that the researcher has access to information about the category of interest in the potential sample pool. Theoretical sampling is particularly appropriate in participant observation methodologies where the researcher has access to varied locations and large numbers of potential participants. However, in the medical system, the greatest emphasis is placed on the patients and their family members are often relatively unknown by medical staff. Theoretical sampling in the present study was therefore hampered by the relative obscurity of patients' husbands to medical personnel.

As the study progressed and it became evident that most of the husbands felt that they were growing closer to their partners in their marital relationships, I attempted to locate a negative case (an example where this was not occurring) in order to broaden the range of experiences. In presenting this request to personnel, staff usually stated that they were unaware of the status of marriages. The best that I could do was to alert staff that I was not restricting the sample to only those who had "good" marriages. One husband was eventually identified by one of the case coordinators as experiencing difficulty within his marriage and was subsequently included in the study.

Theoretical sampling is particularly beneficial in broadening the variability of participants on a range of factors. Fortunately, the participants in the present study were quite heterogeneous in regard to health, employment histories, financial status, type and place of residence, health of wives, and wives' diagnosis lengths, for example. Aside from the dimension of perceived marital closeness, they varied considerably.

Data Analysis

An overview of the data analysis procedure in grounded theory is presented and followed by the specific analytic steps taken in the present study.

Overview of Grounded Theory Analysis

In grounded theory, the data is fractured by coding, conceptually grouping it into codes that then lead to the formation of a theory explaining what is happening in the data. To facilitate this process, the researcher asks two formal questions while analyzing the data (Glaser, 1978). First, "What is the chief concern or problem of the people in the substantive area?" The follow-up question is, "What accounts for most of the variation in processing the problem?" The second formal question is, "What category or what property of what category does this incident indicate?" As the analyst reviews the data line-by-line, these questions are asked continuously. The nature of these neutral questions enable the analyst to stay with what is of relevance to participants as opposed to the forcing of the analyst's perceptions of what "should" be of relevance to participants.

Once the chief concern of the people under study is identified, the analysis reflects the second formal question: "What category or property of a category does this incident indicate?" The constant comparative coding method of grounded theory is comprised of two analytic procedures. The first is engaged by asking the neutral formal question just cited. In the second procedure, incidents, or separate meaning units, are constantly compared to each other with similarities and differences between them noted. As this process continues, concepts, defined as the underlying meanings or patterns within a set of descriptive incidents (Glaser, 1992), emerge. Then, further incidents are compared to concepts, generating categories and their properties. While categories are a type of concept, they are differentiated by their greater level of abstraction. Implementing both analytic procedures, while avoiding preconceptualizations, results in the identification of initial categories and is referred to as open coding.

Substantive coding yields highly relevant categories in the data. Coding is also conducted on a theoretical level. Whereas substantive coding is the summation of patterns found in meaning units, theoretical codes are the discovered conceptual models of relationships between substantive codes. Theoretical codes conceptualize how the categories may relate to each other as hypotheses to be integrated into theory. They emerge and connect the fractured story together again. Glaser (1978) described 18 families of theoretical codes. In the analysis, relevant theoretical codes emerge with no one particular theoretical code gaining prevalence unless it emerges as such. That is, the analyst does not preconceive the relevance of a particular coding family prior to analysis.

Although presented separately above, substantive and theoretical coding are in actuality conducted simultaneously. As the analysis progresses, fewer new categories emerge as meaning units are subsumed by existing categories. The constant comparing, analyzing, and generating leads to the identification of sufficient codes to handle the data; all data fit as saturation occurs.

During the course of analysis, a core category emerges that accounts for most of the variation in a pattern of behavior. Other categories are related to it as it serves to integrate the theory. The core category reoccurs frequently in the data demonstrating a stable pattern of relationships to other categories. Core categories can be any type of theoretical code, a common one of which is process. A basic social psychological process (BSPP) provides for a sense of change and movement over time (Glaser, 1978). The BSPP processes the participants' main problem irrespective of whether it solves the problem. It is recognized that everyone does not proceed through a process in the same manner. However, the BSPP illuminates conditions or variables which give rise to variations, theoretically accounting for them.

From the beginning of the study to its end, analysts are encouraged to interrupt coding and write down ideas (results of asking neutral, formal questions) whenever they arise. This process is called memoing (Glaser, 1978) and is important for several reasons. Once the idea is captured on paper, it can be returned to later and explored and developed further. Additionally, while memos are based on incidents described by participants, they are derived by raising the descriptive data to theoretical levels through conceptually rendering the information. "The successive raising of the description through conceptual abstraction to categories and then theory is explicitly developed in memos" (Glaser, 1978, p.84). Memoing enables the researcher to develop codes further and to locate categories in relation to one another and to other variables emerging from the data. This forces the researcher to theoretically code and to develop hypotheses about connections between categories.

A large fund of memos are generated throughout the study. Upon completion of data gathering, memos are sorted. Sorting connects the fractured data and memos together again as they are sorted in a theoretical outline prior to writing. Categories are sorted on the basis of similarities, connections, and contextual orderings. The resulting patterns become the outline of the eventual write-up of the theory. Writing a draft of the theory affords another opportunity to synthesize categories and if gaps are discovered, the researcher can gather additional data.

Upon the completion of the written draft of the theory, the researcher compares the theory with others in the literature (Glaser, 1978; Morse, 1992). An extensive literature review is not conducted prior to the study in order to avoid preconceptualizing the data. Similarly, the researcher does not seek explanations or theories in the literature while conducting the study. Once the theory is completed however, the researcher reviews the literature to determine how the newly developed grounded theory fits with the existing work. Unique and common aspects of the inquiry are identified.

Study Analysis

The following steps outline the analysis procedure in the present study. Steps are broken down for clarification purposes but in many instances, were carried out simultaneously. For example, substantive and theoretical coding occurred together and the two neutral formal questions were asked throughout the analysis. Memoing also occurred throughout the analysis.

1. Following each interview, I wrote down descriptions of the location, nonverbal communication of the participant, personal reactions regarding the interview, and ideas pertaining to the emerging theory. The latter were memoed.
2. Transcribed interviews were broken down into separate meaning units (incidents). Some meaning units were comprised of a few words whereas others contained several paragraphs. For the first two interviews, the meaning units were paraphrased. However, this time consuming step was dropped upon the review of my data analysis by my supervisory committee. Paraphrasing was seen as redundant with the coding procedures implemented.
3. Meaning units were examined and compared for similarities and differences within interviews. To facilitate this step, the interview dialogue was formatted into a column in tabular form. Each meaning unit in the dialogue was identified with a number and in a column beside it, was given a corresponding descriptive code representing the phenomenon.
4. After each interview was coded in this manner, a second table was constructed. Patterns of similar incidents were grouped together, referenced by the identical descriptive codes and all locations in the dialogue (indicated by the meaning unit numbers). In an adjacent column, a summary of all of the identically coded incidents accompanied the descriptive codes. Each participant reviewed a copy of this table along with his interview transcript.
5. A third table was then constructed wherein descriptive codes pertaining to the same phenomena were given a conceptual label (category). The summaries from the second table were grouped together under the appropriate category label.
6. All interviews were analyzed following the steps above. As the analysis progressed, a list of codes and categories was developed. Meaning units from additional interviews were coded and compared to existing codes. As the research progressed, fewer new codes and/or categories emerged as meaning units fit existing categories. Eventually, all incidents could be fit into existing codes, the point of saturation.

7. Illustrations (quotations) of each category were cut out of interviews and grouped together under appropriate category labels. This step allowed for documentation of the groundedness of each category. Negative cases were included with the differences between the incident and category explained in memos.
8. Memo writing continued throughout the data collection and analysis. Memos contained the emerging theoretical codes and led to the discovery of the core category. The fund of memos was sorted and resorted until categories and their relationships to each other and the core category emerged.
9. Memos contained theoretical implications as well as referenced meaning units. In writing up the first draft of the theory, the theoretical implications contained in memos were illustrated by the quotations from the participants. This ensured grounding.
10. Participants had the opportunity to review the theory and their feedback was incorporated. Members of the supervisory committee also reviewed the first draft and their feedback was incorporated into the final draft.
11. Upon completion of the draft, I reviewed the literature and compared it to the theory.

Bracketing preconceptions. In qualitative research, it is recognized that the researcher is unavoidably present throughout the entire research process. This not only includes the collection and interpretation of the data but also the formulation of the question and determination of what are the data (Osborne, 1990). As the researcher is the instrument in qualitative inquiries, information about the researcher must be included (Patton, 1990) as it is important for readers to have an idea of the researcher's preconceptions. These are articulated through a process of self-reflection called bracketing. The presentation of the researcher's perspectives and orientation assists the reader in addressing investigator credibility and enables readers to take these into account when reviewing the theory. For the researcher, bracketing can reduce the influence of personal biases regarding the studied phenomena as the preconceived beliefs can be suspended during analysis. In increasing his or her awareness of the preconceived beliefs, the researcher is better prepared to avoid forcing the data into the preexisting conceptualizations.

In addition to my personal experiences as outlined in Chapter I, my training has contributed to my belief system. In particular, I have been influenced by general systems theory which was first introduced by von Bertalanffy in 1936 (von Bertalanffy, 1968). Systems can be defined as compositions of elements mutually interacting with one another. Therefore, systems can be viewed on micro or macro levels; that is, on a hierarchical basis.

General systems theory has been applied to the study of families. Wright and Leahey (1984) outlined the contributions of general systems theory to their development of a family assessment and intervention model for nurses. They identified several concepts stemming from this perspective. Of relevance here, it is noted that individuals and family systems are part of a larger suprasystem as well as being composed of subsystems. For example, individuals are embedded in family and neighborhood suprasystems and are also comprised of physical and psychological subsystems. Hierarchies can be broken down further or extended beyond these levels many times over. Another concept stipulates that a change in one family member affects other family members. Pertinent to the present study, illness in one member of a family will affect others (e.g., wives' cancer affects husbands). A third concept relates to the family's ability to create balance between change and stability. Therefore, change and stability can coexist in a system such as a family. The last concept states that behavior is best understood from the point of view of circular causality rather than linear causality. Therefore, for example, a husband's behavior not only influences his wife's behavior but her behavior influences his behavior as well.

As noted earlier in the first Chapter, I developed an interest in the concept of social support when completing my M.Sc. thesis. My knowledge was based primarily on how other researchers viewed the area and I pursued my interest similarly with the subjects in my thesis study. The potential influence of these preconceived concepts, related to structural and functional facets of social support, were continually monitored in the present study by asking myself, "What is this participant saying about his experience?" This continual monitoring helped me to set aside the literature with which I was familiar and remain open to what the participants were saying about their own experiences.

Study Trustworthiness

Sandelowski's (1986) categorization of research trustworthiness was presented previously. The four factors she presented were incorporated into the present study to increase the probability of the study's trustworthiness. The four factors and their respective qualitative criteria were: truth value (credibility), applicability (fittingness), consistency (auditability), and neutrality (confirmability). Each is addressed below.

Credibility was addressed in several ways. Following the analysis of the first two interviews, I provided copies of the analysis to the three members of my dissertation supervisory committee for feedback regarding my interviewing style and analysis. The feedback was incorporated into further interviews and analysis. Emerging categories were also discussed with the supervisory committee. Further, I met periodically with three fellow doctoral students engaged in grounded theory studies. The first three interviews were coded independently by these colleagues and compared to my codes. Issues pertaining to the implementation of the study and other methodological issues were also discussed. These debriefing sessions were a means to address credibility issues (Guba, 1981). Peer debriefing with the supervisory committee members and colleagues provided an opportunity to test insights and be exposed to searching questions.

Credibility in this study was also enhanced through continued contact with the participants, permitting interpretations to be tested with them as they were derived. This strategy, called "member checks" by Guba (1981), utilized the expertise of the participants. If participants are unable to relate to the descriptions and analysis, it is appropriate to question the credibility of the report (Patton, 1990). Credibility is established further upon the completion of the study. Structural corroboration was achieved through comparing every datum and interpretation against all others to be certain that no internal conflicts or contradictions existed that could not be interpreted by the theory. Interpretations took into account possible rival explanations and deviant cases. The completed analysis was presented to participants as a further "member check."

Theoretical sampling addresses fittingness as it is intended to maximize the range of information discovered. As the first four participants described their marriages in positive terms, I requested clinic staff to identify any potential participants they were aware of who were in marriages that were not thriving as well. In the majority of cases, staff were unaware of the status of marriages but one participant was identified as experiencing difficulty. Another strategy toward implementing theoretical sampling suggested by Guba (1981) was to ask participants if they could suggest someone they knew who was in similar circumstances but had very different experiences than they did. Participants were unable to provide the names of additional potential participants as they were not familiar with any other husbands of cancer patients. As described earlier, theoretical sampling was hampered by the relative anonymity of husbands in the medical system. To the greatest extent possible however, theoretical sampling occurred and as noted earlier, the sample was heterogeneous on many variables.

Fittingness is also enhanced through the development of "thick" description of the study context. All contextual factors impinging on the present study were described. For example, the source of participant identification, location of interviews, race and language of participants, etc. was provided. When provided in the write-up, readers are able to determine the degree to which the results fit with other contexts they are interested in.

Auditability refers to the decision trail taken in the study from beginning to end. Readers can follow this trail in the written report. Sandelowski (1986) described several steps in the achievement of auditability: how the researcher became interested in the study subject matter; how the researcher viewed the studied phenomenon (i.e., bracketing); purpose of the study; how participants were included in the study and how they were approached; the impact that the participants and researcher had on each other; how the data were collected; length of data collection; data collection settings; how data were transformed for data analysis, interpretation, and presentation; how various elements of the data were weighted; the inclusiveness and exclusiveness of data categories; and techniques used to determine the truth value and applicability of the data. All of these steps are addressed throughout the manuscript.

Further, memos written during the study outlining ideas and conceptualizations of the data analysis provide additional information for auditability purposes.That is, documentation in the form of transcribed interviews, memos pertaining to the collection, analysis, and interpretation processes was maintained. Following each interview, memos referring to decisions about the data and sampling decisions to clarify problems identified in the data were recorded. Additionally, suggestions and feedback provided during debriefing sessions were documented.

Confirmability is the criterion of neutrality, the extent to which the results reflect the experiences of participants apart from the biases of the researcher. To the degree that truth value, applicability, and consistency were achieved, confirmability was demonstrated. Confirmability assumes significant importance in qualitative research as the researcher is the instrument of data collection and analysis. Subjectivity was reduced through discussing issues with colleagues and committee members. Further, a report of preliminary data analysis categories was presented at a national conference on aging. Those in attendance expressed recognition of the themes as consistent with their experiences of elderly men in different settings. Similarly, a husband meeting the eligibility criteria (with the exception of his inability to participate in the interviewing due to time constraints) read the findings and reported that they were consistent with his experiences. Confirmability was also enhanced by communicating with participants during the study to ensure interpretation accuracy.

An additional issue affecting confirmability is researcher competency. Confirmability in this regard was increased by the experiences I had as a psychologist intern in the cancer hospital, interviewing experience as a counselling psychologist, and the knowledge of general gerontological issues I had developed through course work and conferences.

In the next chapter, the grounded theory of "dovetailing resources" is presented.

CHAPTER IV: THE FINDINGS

This study arose out of my general interest in the influence that women's metastatic cancer had, if any, on the relationships of their elderly husbands. The results constitute a theoretical formulation comprised of an integrated set of conceptual hypotheses about the nature of elderly men's relationships. The emergence of the theory was facilitated by the formal questions asked during data analysis and upon which the logic of grounded theory is based (Glaser, 1978; 1992). What is the chief concern of the research participants? What accounts for most of the variation as they process the problem? What category or property of a category is indicated by each incident? The analysis led to the identification of the participating husbands' main concern and the development of a theory that accounted for variation in the processing of it.

The main concern of husbands emerging from their experiences was how they could best help their wives under the circumstances of their wives' deteriorating health. This concern is described below and followed by an overview of the theory that accounts for how the husbands processed their concern social psychologically. The basic social psychological process, "dovetailing resources," is introduced along with the substantive and theoretical codes. Following the overview, each category is presented in greater detail as the basic social psychological process is described. Quotations from participants are used throughout to illustrate the groundedness of the theory.

MAIN CONCERN OF HUSBANDS: HOW TO BEST HELP THEIR WIVES

Generally, participants were more willing to discuss their wives' situations than their own experiences during the initial stages of interviews. Several commented on how novel it was for them to be interviewed for the purposes of describing their own personal experiences. A few eligible participants who declined to participate in the study, directly expressed their discomfort with talking about themselves and/or intimated that their current situation was irrelevant in light of their wives' deteriorating condition.

As the interviewing progressed, I began to realize that the participants' preoccupation with discussing their wives' cancer diagnosis, treatment regimen, and current health status were reflections of the amount of time they spent thinking about their wives. Further, participants voiced their concerns in regard to how they could best help their wives deal with cancer and health loss. Many of their described behaviors were linked in some manner to enhancing the well-being of their wives. Husbands were interacting with and thinking about their wives far more frequently than anyone else with whom they had relationships. Indeed, wives not only took precedence over others, but often over the husbands themselves. As stated by one participant:

> And while there was an impact on me, the impact was one of, well, what must we do now, what must I do to make my wife feel reasonably well to meet this. (R)

The degree to which participants were preoccupied with their wives was dependent in part on their wives' health status at the time of the interviews. Some husbands were in the midst of supporting their wives during treatment and were acutely focused on meeting their wives' current physical and emotional needs. For other participants, the wives' cancer diagnosis and treatment had occurred years ago and subsequently, their wives had regained strength and led lifestyles comparable to those they had led prior to their diagnoses. Even in these latter scenarios, however, husbands harbored concerns regarding the potential recurrence of cancer.

> Now all these years have gone by and these reoccurrences that she's had, they're not good, even when she gets stomach pains, you know. She, I, I don't sort of highlight it all, but I think, I wonder if it's there, you know. She does pass blood when she goes to the washroom from time to time. (M)

The husbands' primary issue, as identified by them, was how they could best assist their wives in light of health deterioration. The research question, reflecting the participants' issue, therefore became more specific than that used at the beginning of the study. Namely, the question became: How do husbands go about resolving their concerns about how they can best assist their wives in light of deteriorating health?

OVERVIEW OF THEORY

The substantive categories and their theoretically coded relationships to the core category, or basic social psychological process (BSPP), of "dovetailing resources" is briefly overviewed in this section. Of the 18 families of theoretical codes outlined by Glaser (1978), the theoretical codes that emerged in the present study included: processes, contexts, causes, consequences, conditions, and strategies. These theoretical codes link the substantive codes, or categories, into a substantive theory. The categories are underlined and the theory is presented diagrammatically in Figure 4.1 at the conclusion of this overview.

Basic Social Psychological Process: Dovetailing Resources

The core category, or BSPP, emerging from the data was "dovetailing resources." It is summarized at the end of this section. The BSPP reflects a causal-consequence model in the sense that the wives' health deterioration resulted in consequences for the husbands' and wives' relationships with other people, their marriages, and husbands individually. Before proceeding with an overview of the theory, it is necessary to consider the contexts within which the core category exists.

Contexts

Although obvious, it is important to draw attention to the fact that husbands and their marriages do not exist in social vacuums. This social context is of particular relevance in that although husbands are preoccupied with the health difficulties of their wives, they are also engaged in relationships outside their marriages. They interact with family, friends, and neighbors. Further, they have established some form of relationship with their wives' health care personnel. A few husbands additionally drew attention to the meaningfulness of the spiritual realm to them and discussed their personal relationships with God.

Less obvious in the social context is the fact that just as both spouses have individual relationships with people, others interact with the partnership as an entity. Husbands and wives, as couples, have relationships with others. Furthermore, interaction can be initiated by either side. That is, others can initiate interaction with individual partners and/or the partnership and vice versa. A related phenomena is the fact that partners individually or collectively can provide assistance to others and also receive assistance from other people. Dependent upon the level of their wives' health deterioration, participants prioritized their efforts on their marital relationships and sought more assistance from others than they reciprocated in turn. As a consequence, reciprocating support with others is only addressed briefly in this presentation.

The identities of the participants were indelibly stamped with a sense of partnership with their wives. For example, husbands often referred to themselves using the plural "we" rather than singular "I" or "me". The context of their marital beliefs pertains to the beliefs participants held about marriage and their commitments to the institution. They placed great emphasis on keeping their marriage vows. A related context, marital history, highlights the number of years husbands and wives have spent in building their partnerships and pays homage to the number of challenges they have overcome through their decades together. In this vein, the husbands' patterns of speech may be indicative of the passing years spent with their wives, approximately twice as many as spent single. These participants have therefore had many years to grow accustomed to thinking about, and being, marriage partners.

> My wife and my lives are, we're together. It's a unit. (R)

Cause

The generic description, "health deterioration," was selected because although the main selection criteria of participants was their wives' metastatic cancer, health complications were not restricted to the effects of cancer in the sample. Further, there was considerable variation in the severity, location, time frame, etc., of the health deterioration. It was rarely isolated to one specific event; rather, health deterioration was a series of events culminating in functional losses of some form. The health deterioration, of whatever magnitude, had consequences for other people with whom husbands interacted as well as for the husbands.

Consequences

The health deterioration of wives had consequences on others outside the marriage. Husbands described the "focused attention on wives by others" and the "altered interactions" with others as results of their wives' health deterioration. The nature of relationships changed primarily in positive ways (e.g., increased supportive contact). As described previously in addressing the social context, either party in a relationship can initiate some form of interaction with the other party. This phenomenon is of relevance here because in light of the women's health deterioration, people began to provide unsolicited assistance and contact to wives individually, collectively in partnerships, and to a lesser extent, to husbands individually.

It is important to note that the participants' lives were not necessarily governed by cancer (e.g., one husband commented on his ability and his wife's to "get on with living life" as opposed to allowing cancer to dictate their lives). Particularly under circumstances where their wives' health had stabilized or improved, husbands were engaged in maintaining marital partnerships. Health-related changes were incorporated into their lifestyles as they returned to pre-health deterioration normalcy. Furthermore, husbands of wives with improved health were more likely to be increasing reciprocity with others as more time was available to them.

While it is recognized that the health status of wives fluctuated as opposed to remaining on a constantly worsening trajectory, the health of most wives was described by their husbands as deteriorating. The main consequence of their partner's deteriorating health was the employment of their chief strategy - prioritizing the marital partnership.

Strategies

The strategy of prioritizing the marital partnership in the face of the partner's declining health had ramifications for the marriage as well as relationships with others. One result of employing this strategy was decreasing reciprocity with others. Participants not only reduced their interaction with others but were also apt to decrease their time spent engaging in personal interests (self care). A strategy related to prioritizing their marital partnership was assuming responsibility. In order to understand this strategy, it is helpful to divide the roles of participants along marital and individual lines. The consequences of the wives' health deterioration were observable at the marital level insofar as marriage relationships were affected and participants altered their roles as husbands. At the individual level, participants dealt with the impact of their wives' losses in different ways, sometimes without sharing their personal struggles with their partners. There is obviously considerable overlap between these two levels but in separating them conceptually, different processes are observed. As described later, the dovetailing resources BSPP integrates the two levels again.

The marital level is considered first in this chapter as consistent with the overview thus far, participants primarily viewed themselves as marital partners in response to their wives' health deterioration. In assuming responsibility for their wives, husbands became engaged in a strategy that is also a mini-social psychological process, dovetailing marital resources. This preferred first phase of assuming responsibility reflected how participants sought to continue their married lives as independently as possible under the health-related circumstances. They dovetailed their personal resources (self) with their partners' resources (wife) and drew from their marital history, a history of overcoming diverse challenges through enacted teamwork. A component of the dovetailing marital resource mini-process was the desire to promote partner independence as much as possible given the level of functioning due to health considerations.

In many instances, this preferred mode of marital coping was sufficient for everyday life. However, participants (and by their accounts, their wives as well) recognized they were not completely self-sufficient as a marital unit. At the very least, this was evident through the interventions of formal services in treating the wives. The second phase strategy in assuming responsibility in caring for their wives was accessing external resources. Husbands requested assistance on behalf of their wives or for the partnership (e.g., domestic assistance where arguably neither spouse benefitted more than the other). Prior to enacting this strategy however, several conditions exerted their influence on the decision-making process. Conditions included the wife's health status which, as discussed previously, was prone to fluctuate. If stabilized or improved, participants obviously had less need of assistance in health-related issues. Similarly, the husband health status differed between participants and could fluctuate, thereby influencing the likelihood of requesting external assistance. Some participants were restricted in terms of their abilities to carry out certain tasks. Even with physical limitations, however, husbands assumed responsibility for their wives by making arrangements for someone else to fulfill a given task for example.

Several conditions emerged in view of the social context. The husband's perceptions of the willingness of others to assist, availability, and accessibility of others influenced their decisions to solicit external resources for assistance. Another condition was receiving unsolicited help. The amount and nature of unsolicited assistance received from others recalls the earlier discussion of the social context and the consequence of the wives' health deterioration on others wherein people focused on wives. The unsolicited assistance was usually directed toward wives specifically or the partnership as a unit. If husbands judged the amount of assistance to be sufficient, they did not request further help. While the consequences of receiving unsolicited assistance were usually favorable, not all interactions were viewed as such. An additional condition was the extent of receiving unsolicited unhelpful "help". Husbands did not describe others as intentionally intending to harm them but in some exchanges, negative consequences did arise. Participants tended to associate negative types of consequences (e.g., misdiagnoses, premature removal of aids for daily living) with their wives' formal networks rather than informal networks. The result of these types of interactions was usually an increase in the work load of husbands or other type of strain. Participants emphasized that in general, they perceived interactions to be positive and people frequently exceeded their expectations.

The primary condition influencing the husband's decision to employ the strategy of accessing external resources was recognizing marital resource limitations. This condition has been implicit in the other conditions. Obviously, if participants did not perceive shortcomings at some level, they would not request assistance from their external resources.

As presented above, in the second phase of assuming responsibility for their wives, participants accessed external resources. Participants viewed the people with whom they had relationships as resources and in requesting assistance from them, experienced two general consequences: solicited help or unhelpful "help".

These responses are incorporated into the BSPP of dovetailing resources but in order to fully understand the BSPP, it is necessary to return to a consideration of the strategy of assuming responsibility. Now, however, the focus will be shifted to the individual level and the strategy considered in light of caring for the self. It is recalled that the partner's health deterioration had ramifications for husbands as individuals as well as in their roles as marital partners. Husbands were impacted by their wives' health losses and dealt with some of these issues individually, outside their marital relationships. Participants engaged in several related strategies in caring for themselves: monitoring personal health, keeping active, and seeking respite.

Assuming responsibility through caring for the self was contingent upon the spouses' health as in times of crisis or destabilization, participants prioritized their efforts and attention toward their wives. Indeed, on occasion some participant's health suffered considerably as they sacrificed their own well-being for their wives. As soon as they felt able, they pursued some avenue of self care. Some realized the importance of caring for themselves as an extension of their assumed responsibilities of caring for their wives. Namely, if they didn't care for themselves and became incapacitated, who would care for their wives? As an aside, it could be added that with the increased attention on wives/patients, some participants felt they needed to care for themselves because if they did not do so, they were uncertain who else would.

In the first phase of caring for themselves, participants engaged in relying on self as a personal resource. This strategy was indicative of their preference to cope as independently as possible and parallels the first phase at the marital level in this regard. Comparable to the marital level, participants realized that they had limitations in terms of their personal resources and engaged a strategy of accessing external resources. Spiritual resources were included to reflect the importance that participants with spiritual beliefs placed in their relationships with God. As at the marital level, several conditions influenced the decision to request external assistance at the personal level. Most conditions were very similar between levels. That is, at the individual level, participants were affected by conditions including their wife's health and their own health (husband health). Reflecting the social context, perceptions of the willingness of others to assist, availability, and accessibility were conditions affecting the participant's decision to seek personal assistance as was receiving unsolicited help. There were two further conditions observed at the individual level. Participants described the support they experienced personally when their partners were the targeted recipients of assistance (solicited or unsolicited). This indirect support could be in different forms than that provided to their wives. For example, one participant experienced pleasure and satisfaction in observing how his children assisted his wife. Although he performed the bulk of care, he felt he was not alone in the face of such evidence of their concerns for their mother. Indirect support was often in the form of emotional support and may partially at least account for why husbands seldom requested this type of help - they were already receiving it. A related condition affecting participants in accessing their resources was their level of self-disclosure comfort. For the most part, participants expressed greater comfort requesting instrumental help than emotional help. The final condition, consistent with that of the marital level, was recognizing personal limitations. In the face of acknowledged personal shortcomings, participants sought assistance.

The strategy of accessing interpersonal/spiritual resources led to two general responses - solicited help and, to a lesser extent, unhelpful "help". Both responses subsequently became integral in the BSPP.

Basic Social Psychological Process

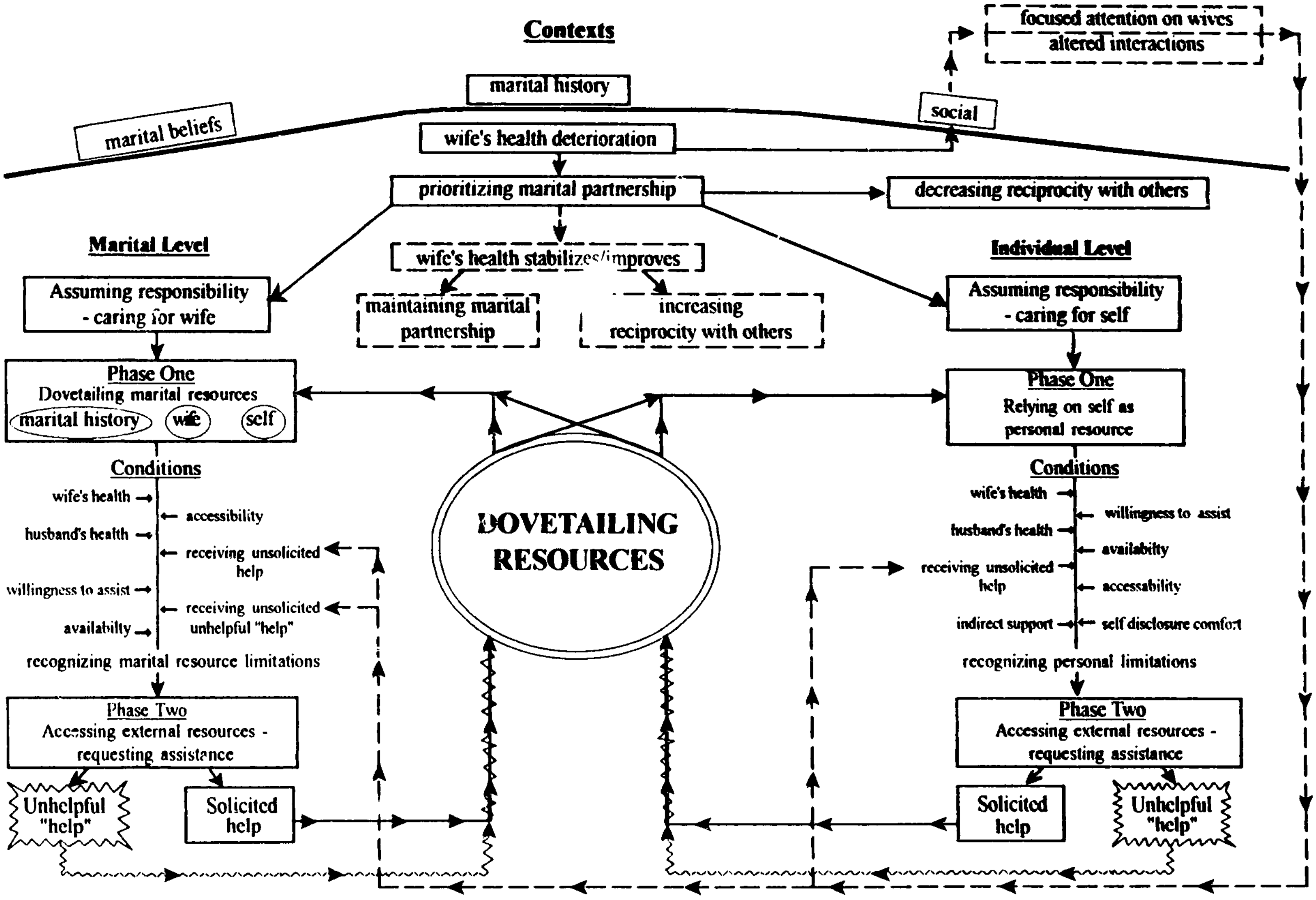
The core category of dovetailing resources reunites the marital and individual levels as depicted in Figure 4.1. At the marital level, it is recalled that in assuming responsibility, as demonstrated in caring for their wives, participants engaged in their preferred mode of dovetailing marital resources (i.e., self, wife, and marital history). At the individual level, participants preferred to rely on themselves as much as possible. It must be emphasized that the preferences for marital self-sufficiency and self-sufficiency were simply that - preferences. Participants did not view themselves as failures in seeking external assistance. Their decisions to do so were influenced by conditions at both the marital and individual levels. Participants dovetailed their receipt of assistance - solicited or unsolicited, helpful or unhelpful - with their own efforts. Husbands fit the assistance they received into their preferences for autonomy and adjusted the degree to which they accessed external resources accordingly. In doing so, they demonstrated considerable control over their situations but they recognized the elements over which they had limited control (e.g., their wives' and own health, unsolicited assistance, degree of helpfulness of responses to assistance requests, etc.).

Particularly during times of acute health deterioration, husbands dovetailed their resources together in a manner that best suited the priority they placed on their marital relationships. Following stabilization or health improvement (if applicable), greater emphasis was placed on self care and normalizing relationships with others in terms of increased reciprocity. In a similar vein, requested assistance from others specifically pertaining to health-related difficulties was curtailed as it became easier to maintain greater marital and individual self sufficiency. Under these circumstances, greater companionship and socializing interactions emerged.

At this point, it would be helpful to pause and review why the BSPP was entitled "dovetailing resources." In the overview thus far, it is evident that participants considered themselves as a resource to their wives, themselves, and to a lesser extent to other people in light of their wives' deteriorating health. Husbands also identified the people with whom they had relationships with as resources that they could access. Regarding the word "dovetailing," a definition is "to fit together into a unified or coordinated whole" (Webster's Third New International Dictionary of the English Language, 1986). This definition is consistent with the manner in which husbands endeavored to fit together their personal resources with their external resources in order to best assist their wives. Implicit in this metaphor is the sense that husbands assumed an active role in the process, assuming responsibility for fitting the resources together. Further, "dovetailing" connotes a carpentry image pertaining to the interlocking dovetail joint. While it cannot be assumed that resources were consistently fitted together as tightly as a well-crafted finished product, the BSPP can be viewed as a "work in progress" wherein the goal is to establish such a product. At times, the resources may fit snugly, while at other times, the "tenon and mortise joints" are being crafted to better fit with each other. Finally, "dovetailing resources" fit with the experiences of participants in a figurative sense given the comfort most professed in working with their hands, shaping and modeling things to achieve a goal.

The dovetailing resources BSPP is summarized in Figure 4.1 which follows.

Figure 4.1 Basic Social Psychological Process: Dovetailing Resources



DESCRIPTION OF BASIC SOCIAL PSYCHOLOGICAL PROCESS: DOVETAILING RESOURCES

The remainder of this chapter contains the description of the basic social psychological process (BSPP) that emerged from the study - dovetailing resources. In order to better understand the BSPP, the social and marital contexts are presented first. This is followed by an account of the diverse nature of health deterioration and the resulting consequences on other people within the couple's sphere of influence as well as on husbands themselves. The strategies employed by participants, as well as the conditions affecting them, are then examined and followed by a more complete description of the BSPP.

Contexts

Glaser defined context as a "condition of overriding scope, under which a set of related categories and properties occur" (1992, p.65). "Dovetailing resources" occurs within several contexts. The first, social context, reflects the embeddedness of people within relationships. While it is recognized that participants were engaged in many relationships simultaneously, it is clear that they valued their marital relationships the most. The concern of participants for their wives, as well as their actions undertaken on behalf of them, arose within a second context, that of their strongly held marital beliefs. This is not to say that all participants were equally devoted or committed to their wives. Rather, in general, participants demonstrated commitment toward their wives and were actively assisting their partners in some form or another. A related context, marital history, is a testament to the couples' marital beliefs and the growth of a partnership history spanning at least four decades.

Each of the three contexts is described below.

Social Context

While the focus of the present study is on husbands, it is acknowledged that individual partners, as well as partnerships, exist within a social context.

> We can't exist in a vacuum ... We've got to be involved with other people and we've got to have our own ideas tempered and tested by what other people say, and so we need more than just acquaintances. We need people that we can talk to and in a sense, let our hair down with. (R)

There are relationships that the couple, as an entity, have with others and relationships that each partner has with others as individuals. Husbands had relationships with family, friends, neighbors and to a certain extent, with their wives' health care personnel. A few participants had developed meaningful relationships with health care personnel but most of these relationships were at superficial levels.

Levels of contact with people were affected by historical factors such as the nature of the relationships prior to health deterioration, the degree to which contact was sought with others, and personalities of each partner.

> We've got friends at [former city residence] of course, and not too many. We didn't, we never, we never associated with a whole bunch. We're not those, you know, we don't people in and out. We've never had people in and out of the house all the time, like, that's the way it gets to be, and your friends become enemies ... Basically, my wife is a bad mixer. She, she's got a shy disposition. She's not snobbish or nothing like that. (M)

> We didn't go out of our way any more than they went out of their way to meet us. If we met them in a cafe or then of course we'd sit down and yap and talk but, we didn't go out of our way and they didn't go out of their way to, to meet ... We never, from day one we never were a great couple to visit - to go to other peoples' homes. (E)

Within families, expectations of contact and/or support were lower for siblings than children. The lower expectations were partially attributed to proximity. It is common for husbands of this cohort to have immigrated to Canada and consequently, siblings can reside in other countries or be scattered across Canada. Contact with them may therefore be relegated to special occasions with face-to-face interaction occurring infrequently, if at all. Physical distances may be compounded by emotional distance as well. Under such circumstances, little contact, much less assistance, was expected.

> After 10 years you don't know a person really. Fourteen to 17 years, you know, you really don't know them [siblings] at all. They sounded like they were really sorry but, I really don't know ... We're not a close knit family anyhow ... We don't phone, we don't write, we don't - we're strangers, that's all. (E)

Reciprocating Assistance

The majority of the results presented below pertain to the receipt of assistance and imply that participants were engaged in one-way relationships with others. However, as will be evidenced with respect to marriages, husbands both provide assistance to their wives and receive assistance from them. Similarly, husbands (and wives) not only receive assistance from others, they also provide it to others. The current provision of assistance to others may be hampered by the health of the husband and/or wife but viewed over the long term, informal relationships were reciprocal.

The exchange of assistance could be closely matched to that received. This was most typical with friends and neighbors.

> He [friend] won't take any money. He will, we will, like I returned it [friend's assistance] in favours of different things ... Horse trading. (E)

> In summer time, maybe some tool that you needed or haven't got or maybe you need some little item that somebody have, and I've given the same thing. And in the morning, when he gets up, well, he's out there in the snow storm, he's out there all the time sweeping snow. He'll come right up to the end of the driveway on the sidewalk. And I'l! so the same for him and the same for the other fellow. Whoever happens to be first will clean the whole sidewalk and next time if I'm there first, I'll do it or, shovel it away if it is not heavy. (B)

Reciprocated assistance could also take a very different format from that which was received. This was particularly evident in exchanges with family members. Families did not receive comparable assistance as health complications, for example, often prevented husbands and wives from providing this. Nevertheless, family members requested and received help from their parents.

> They [children] all (pause) mature and they all have their patterns and I don't interfere, we don't interfere ... Oh, they come for consultation ... they will ask about things they're not sure about, especially home repairs (chuckle). (B)

> Our son is working on a movie. He shares his ideas with us and uses some of my equipment to help him in what he's doing with his animating studio. We, he came over and brought in some firewood for me over Christmas because he knows I have difficulty bringing the wood in from the woodshed at the back of the property. No, you know, mutual help back and forth with all of them [children]. (R)

With the deterioration of their wives' health, husbands prioritize their marriages and consequently, have less time to reciprocate the assistance they receive from others. As the participants spoke predominantly about their marriages and the assistance they received from others, the analysis reflects their preoccupation with the same. That is, the assistance provided by husbands to people other than their wives is deemphasized to reflect the priority they placed on the assistance they provided to their partners. Nevertheless, it is imperative that participants not be viewed solely as recipients of assistance - they provided assistance to others as well.

Marital Beliefs

Participants were guided by their belief systems concerning their roles as marital partners. These beliefs were initially voiced publicly when their wedding vows were exchanged decades ago. Promises were made to their partners (and reciprocated) that they would remain together whatever the circumstances that arose during their lives together; "for better or worse."

> Our love for one another was always strong and we got married for better or worse - that was it you know. Till death will us part and all that you know. And we believed that. (P)

Participants considered themselves to be one with their wives and sought to grow closer together. Through the years, they had placed premiums on their marriages and families. Their first priority was their relationship with their wives.

> What is so important is the relationship with one's spouse and then one's family ... And one can get involved in other things. One can get involved in organizations, maybe it's making money, maybe it's in the business or something but they all pale into insignificance to the relationship within the family structure ... It's alright to be out there doing all these good things but in the meantime, is your family and your wife suffering while you're doing all these good things outside? (R)

Marital beliefs included an expectation that challenges would be faced throughout their married lives. Participants were aware of the likelihood that they would experience both prosperous and difficult times in their marriages.

> We got married for better or for worse and we have to take both. And that's what we do. (J)

> [Wife's general physician] told me, not that he, we don't harp on that subject at all, but he did, he did tell me, he said, well, cause there has been a couple of times when it, when it was pretty hard. When I was, this was a couple of years ago, when I was at work, and was, my wife was giving me a hard time for no apparent reason you know (pause) and I, I accepted it. I took it, like you know. I think that was the times, he said it more than once, he, he's told me, "I don't know how you handle it." He said, "you're pretty remarkable ... what you're handling there." I said, "oh well, it's all part of married life." (M)

Husbands therefore expressed both an expectation and acceptance of adversity in married life.

Marital History

The participants' belief systems about marriage as an institution and more specifically regarding their own marriages, had been tested over several decades of married life. Individual marital histories were extremely varied but collectively, participants and their partners had overcome an array of challenges (e.g., poverty, deaths of children, moves, etc.). The existing marital framework was constructed over many years and "marital history" refers to the couples' efforts through the years to nurture and develop their partnerships. Their current marriages are reflections of past teamwork. Together, with their partners, they had accomplished much in the past.

> We started out from scratch. We raised a family and when I was off work there through no fault of my own, when things were rough, and she started to work and (pause). Everything, we worked together for what we have ... I had a chance to work a different shift so we worked different shifts so somebody was always at home. We didn't have to worry about the kids, leaving the kids on their own. (B)

Husbands expressed pride in what they had accomplished with their wives in the past. In general, a sense of self-sufficiency as a couple prevailed, an attitude that they had looked after themselves and one another as independently as possible.

Throughout their married years, husbands and wives cared for one another and assisted one another. In response to their needs, husbands received help from their wives in the past.

> My wife is a very good listener, you see, and I have to confess, that I am too much of a talker (chuckle). They try and always tell me that, you know, to listen and not to talk so much ... I have to learn, she says, now that I have a little bit of a hearing problem, she says, "you've got to watch their lips, that's how you can tell if they're talking or not, 'cause you butt in and talk when they're talking!" (chuckle) ... She's a help to me spiritually ... I could have married someone like Job's wife who said, "Why don't you curse God and die?" But you see, she's always helped me no matter what complications or troubles we've had in 40 years of marriage (pause). So that's, that's, you know that's the thing that binds you closer, if I may say, than even sex. (T)

Wives were viewed as confidants by husbands. The degree of openness varied between participants and their wives but for all, wives were the most trusted persons in their lives.

> Everything I have goes into one joint account and she could write whatever she wants ... but I mean, my gosh, we've got implicit faith, trust, and love between us and we can talk about anything ... We both can talk, about, freely about things one to another sexually and no problems there whatsoever ... There's nothing I don't talk to my wife about. Yeah, I don't have like what some people, I know some of my friends say things to me and then I say, "does your wife know about that?" "Oh no, I wouldn't, I wouldn't dare talk to her about it." And I think how strange ... My wife is my (pause) I don't know what the word is, soul mate, or whatever the jargon is today but, no my wife knows everything. (R)

Over the years, participants developed unique patterns of communicating with their partners. Specific communication patterns varied considerably between husbands and wives in regard to their openness but husbands were comfortable with the styles they had developed together with their partners.

> [Wife] and I, we don't communicate a great deal. We're not big talkers. We, go down the highway, like we drove to [southern state] and I s'pose a six or eight hour day we wouldn't say ten words to one another you know. We just like, just like our silence. (E)

> My wife and I can talk about things and do talk about things and that helps to smooth the way. (R)

Couples had adjusted to numerous developmental challenges throughout their marriages, the most recent of which was retirement. Retirement introduced many changes in marriages with the most noticeable being the increased time spent with spouses. This change was particularly dramatic for those husbands who had formerly worked out of town (e.g., railway and construction industries). Other husbands underwent considerable adjustments too as they had devoted much of their time to work and their careers.

> I don't work anymore. I mean we're home together now ... [I was] gone all day for 14-15 hours. I mean, you start working at 3:00 in the morning and you come home around 5:00 in the afternoon. (J)

To summarize, the marital history context encompasses the development of teamwork leading to a sense of self-sufficiency as a couple. As partners of one another, spouses had met each other's needs and husbands viewed their wives as trusted confidants, communicating in their own unique ways with them. Many challenges had been faced and overcome through their joint efforts.

Wife's Health Deterioration

The women's health deteriorated within the social, marital belief, and marital history contexts. Health deterioration is viewed as a causal agent as it precipitated changes in the relationships of the participants. The generic description, "health deterioration," was selected as although participants were selected on the basis of their wives' metastatic cancer, other health complications often co-existed with the cancer. Not all of the wives' health complications were attributable to cancer. Furthermore, there was considerable variation in the health histories. Some had enjoyed vigorous health prior to the cancer diagnosis while others had experienced life-long health related difficulties and were concurrently affected by them and the cancer. Indeed, for some women, cancer-related difficulties were even less problematic than pre-existing or co-existing health difficulties.

> She's got a serious back problem she's had for years. She had a fall ... I guess it, I don't know, done something to her spine anyway, slipped a disc or whatever and then, like, when you're young you can handle these things, and then later on in life it comes back. For quite a few years now she, she's been unable to stand on her feet for too long, like walk around stores like a lot of people do, you know. But now, of course, it's, it's really deteriorated and she (pause). It's aggravated with arthritis too. So you could say she's, it's not just the cancer that's in her case, it's very often she said she, she could put up with the cancer, it's, it's her back, you know. She's often said that. (M)

> See my wife over the years has been hospitalized quite a number of times. She has had some rather unfortunate health problems [related to her back], not just with the cancer. She's been in the hospital a good number of times over the years. She's gone through an awful lot. (R)

Husbands of wives with chronic health problems were therefore quite familiar with health-related issues. However, it could not be assumed that the presence of past and/or on-going health difficulties necessarily made for effortless adjustments to the discovery of cancer in their wives.

> I don't really see that [wife's history of back problems] as a factor that made it any more or less difficult to take that initial stage when the cancer was discovered. (R)

In contrast to these circumstances, the discovery of cancer for husbands of other patients represented the first time they ever had to address a significant health issue in the partnership. Further differences were noted in the individual patient responses to the disease and subsequent treatment. Some wives were minimally affected by the cancer but most, however, experienced substantial functional losses; whether temporarily or chronically.

> After [chemotherapy] she was sick and she couldn't walk very well - in fact, later on she was in the wheelchair. (E)
>
> She hasn't been out for about three weeks now, she's been in pain and this and that, but up until three weeks ago, we was going out all the time. It doesn't matter where, if I had to go to [city], she'd come with me. She was coming out, and enjoying it, too, you know. We'd even take sandwiches, you know, and eat them somewhere. (M)

For most participants, treatment resulted in considerable uncertainty regarding the predictability of their wives' functional capacity.

> Days are different. She can be up one day and down the next (pause) which is, I think, pretty understandable depending on how she's sick, how sick she is on that day. 'Cause this thing seemed to, seems to vary day to day. (A)

In addition to functional losses associated with cancer, some wives experienced attitudinal changes.

> So this has been a continual come-back. I mean she's beaten it every time. And I think the word 'beaten' is not the right word either. She's overcome it because of her great strength, you know, "this isn't going to get me." And I know initially her attitude was well, [daughter] was 5 and [daughter] was 7 and, my wife just said ... "I can't have this take me because I've got too much to do with raising my children." And I'm sure her positive attitude was the one that stood her in good stead. For the first time I'm detecting now in my wife ... a little feeling of "gee, what's going to happen next?" I mean, "you know this is the third or fourth time." (R)

A cancer diagnosis does not preclude the onset of other diseases and further functional losses.

> She had this operation where she had to have her hip, right hip reinforced. Two pins, the doctor put in ... The bones were getting weak. I don't think the cancer had anything to do with it, but he just, like the

> doctor said, he says, "old ladies don't fall down and break their hip," he said, "the hip breaks while they're walking and they fall down." And they order her to bed, not to walk because it was fragile ... she was able to walk because she had therapy. Went there [physiotherapy] after (pause) she had the wheelchair, but then she was able to walk and get around (pause). And that's when the, after the stroke, this is, she hasn't been able to walk since the stroke. (B)

In summary, it is evident that "health deterioration" is a broadly defined cause. Wives may have had long-term histories of health complications or conversely, experienced their first health complication with the cancer diagnosis. The patient's health can stabilize, improve, and/or deteriorate rapidly - or slowly. There may be negligible or significant impacts on the functional capabilities of patients. In short, health deterioration is not an homogeneously defined event with a clear-cut trajectory.

Consequences of Health Deterioration

The course of health deterioration has been demonstrated to be extremely varied. Nevertheless, a cancer diagnosis still elicits a sympathetic, if not empathic, response from most people as it is still often associated with death. However difficult to contain within well-defined parameters, the deterioration of health has many consequences. We now examine the consequences of health deterioration on other people within the couple's network as well as on the husband individually. The impact on others is examined first as this establishes the backdrop from which husbands' acts are viewed. This depiction is followed by an account of the consequences on husbands. Participants were impacted by their wives' health deterioration and developed strategies to deal with the impact on a marital level as well as an individual level. Both levels are discussed in detail.

Consequences of Wife's Health Deterioration on Others

The social context was presented earlier. Participants described their perspectives on how other people were affected by their wives' health deterioration. Two related types of consequences were identified: focused attention on partners and altered interactions.

Focused Attention on Partners

Within partnerships, wives may have historically garnered more attention from others than their husbands. For example, wives may have historically had more friends and interacted with their children more frequently than husbands.

Regardless of the past levels of attentiveness to each partner however, husbands noted that following their wives' health deterioration and/or cancer diagnosis, other people tended to focus on their wives more frequently. As will be discussed later, this outcome parallels that which occurs with husbands individually as they too focus on their wives.

The power of a cancer diagnosis overshadows most other health conditions. For example, one participant, diagnosed with kidney complications and undergoing dialysis four times daily, experienced considerably more lifestyle disruptions than his wife. Nevertheless, this husband noted how his wife received more attention than he did.

The increased attention directed toward wives was evidenced in different ways. For example, husbands fielded many enquiries about the status of their partners.

> The people [at church] all come up and then you have to talk ... And she gets tired out from that. It's not from the church service ... [If husband attends alone] Well they ask, "how is [wife] doing? How is [wife] doing?" Oh yeah. (chuckle) Then you have to tell them. (J)

People also indicated their concerns for wives through prayer.

> We have a prayer meeting every second Sunday at our church ... A lot of people get together and we pray the rosary and other prayers and singin hymns and all that ... They always bring up like when we're praying for maybe other people and relatives of somebody else or somebody that's not doing well at the time, we pray for them but they also remember my wife also in the prayers you know. That always comes up. (P)

Participants sensed that some people underwent attitudinal changes following the cancer diagnosis. Some people seemingly assumed that the couple's lives revolved around the wife's cancer. Others seemed to assume the worst - that the wives were going to die.

> They're [acquaintances] enquiring because they want to know if she is still around, is she died or whatever, you know. Basically, I know, I feel that, you know I feel, I, especially when you haven't seen a person for, you know, say a couple of months and they, they must be wondering, "I wonder if so and so's wife has died?" (M)

Husbands provided information about their wives in response to the enquiries of others but at times were uncertain of what to divulge.

> I guess the biggest problem in that relationship is, how much do you tell anybody about the extent of what's happened. My wife, for example, really doesn't want people to know. She's not one that wants to be at a wailing wall and say to people, "look, this is what's happened" ... My own reaction is my wife doesn't want people to know enough. I would tend to tell them too much. But somewhere in between there's a happy medium to suit. (R)

In general, husbands expressed comfort in their roles as informants, describing the conditions of their wives to others.

> I confide in a lot of people you know. Like I meet people in the church and meet people at meetings ... if she's not there ... or if she's in another group ... they'll ask me how she's doing or something like that you know. I don't have any problem you know in confiding with them because she is doing good ... She's not back to what she was but she has made a great recovery. (P)

Participants also subtly reinforced the inclination of others to focus on patients by volunteering information about their wives' condition. As most participants were reluctant to disclose their personal experiences to others in regard to their partner's illness, it is not clear if this reluctance precipitated the volunteering of information about their wives. Participants could simply be more accustomed to talking about their wives than themselves. Alternatively, some may have become chief spokespersons by acclamation because of their wives' incapacities and subsequent withdrawal from others. Or wives, by their dispositions, may be reluctant to disclose personal information and therefore rely on their husbands to speak on their behalf.

Altered Interactions

Changes in the couples' relationships occurred as a result of the wives' health deterioration. Some changes were in a negative direction as people avoided the couple, presumably because of the wife's health problems.

> I - we've dug into it and dug into it and there's no way that there could, anything else could have happened except sickness. I, I really don't know ... If it's sickness and that scares him then that's his privilege. That's - it could be his nature and he should know that cancer's not, is not spread, is not contagious. It's possible that he's known us so well that when he's seen [wife] so sick, it might have just got to him. I don't know really ... Someday i s'pose (chuckle) some day I might ask him. (E)

In other instances, couples were restricted in their abilities to socialize; to initiate or follow through on social invitations.

> The retirees, they have a thing. I have correspondence all the time. I pay the membership fees in to them. They organize things like tours and barbecues they have and stuff like that, but I don't go because I can't get away ... Our biggest trouble is ... there's too many places that do not have washroom facilities. (B)

Partnerships were most often affected by the wives' health condition in a positive direction. For example, the level of contact increased for some.

> We were on the executives [of social club] for 10 years so that was how long a lot of people got to know us ... But then you lose contact with a lot of those people over the years that they don't - but when she had her illness then they came to her assistance the first time. The lines sometimes will, you'll be just off the phone with one person and another person would phone ... They were anxious to know that she was, whether she was doin well ... (P)

Aside from increased contact, husbands attributed the enhanced closeness in some of their partnership relationships to their wives' health deterioration.

> I think it [cancer] has brought us [siblings] closer, you know, in, in a sense you know. We were pretty close you know. We had a good relationship even though we were far apart [overseas]. We wrote to one another one thing or the other you know on both sides of the family and we never had any differences or anything like that ... So we had a good relationship and I think it just got stronger. (P)
>
> The health problem with my wife is just, is just, made it [family] more solid. Because they, they tried to be, everybody tries to come, make at least one (pause) come and visit at least once a week. If they can't come on weekends, they will come in the evening, check up on us. No secrets. (B)

The current level of contact and quality of relationships may not be affected (or at least minimally) by the wives' health condition - particularly if wives had not suffered appreciably or needed to alter their lifestyles significantly.

> The people that we socialize with or go to prayer meetings and prayer groups and all this, call and visit us or then we see them weekly ... they're very close, you know, to us. (P)

In general, the personal relationships of husbands, as differentiated from the couples' relationships, were relatively unchanged following their partner's health deterioration. Contact was more likely to increase than decrease with friends although the latter did occur in some cases.

> He used to be here quite frequently and sit down and yak and two or three hours you know. And after she [wife] got, she got the cancer, then he just shied away just like a dog that had a kick in the rear. He, he just wouldn't come near ... The last time I talked to him on the phone he said he'd phone back and he never did phone back. Whether he didn't want her company or (pause) but before that it was just, you know we were, I think we were real buddies. (E)

It is possible that husbands avoided discussing interactions in a more negative light during interviews with me, perhaps not wishing to appear ungrateful toward others in their lives. This possibility cannot be dismissed entirely as husbands were not observed interacting with others. However, their overall sense of gratitude for the assistance provided by others seemed to reflect their sense that people did much more for them than they expected. Husbands expected little in the way of increased contact and/or support from family and friends in light of their partner's health deterioration.

Consequences of Wife's Health Deterioration for Husbands

Given the value placed on their marriages, it is not surprising that participants described the deterioration of their partner's health as having considerable impact on them. As stated earlier, a history of health complications did not necessarily inoculate participants from the impact of cancer or other health losses in their partners.

> It [wife's cancer], it's (pause) well it's forced on you and (pause) all you can do is feel real sorry for her (pause) but nothing you can do about it ... it does make you feel quite inadequate, 'cause this whole situation tends to make you feel you've lost control of your life, which (pause) I think most people (pause) can, decide what they want to do and do it. But, here you can't. (A)

> When they had to operate on the, take the breast off, it kinda hit me that, oh my God if she's gotta go through that [chemotherapy] again then, you know it's horrible - and when Dr. G. told us that it was in remission, well it just like, 40 below and you put on a big coat just to, such a relief to have somethin - or takin a big coat off when its 80 above, whatever, you know, it's such a relief to find that [the cancer is in remission]. (E)

From the perspectives of participants, the health deterioration of wives could have negligible, negative, or even beneficial effects on the partnerships. Strong marital relationships remained strong and therefore, the health losses had minimal impact.

> You have to cope with it [wife's health] I mean. That's what we do, but, the relation is not changed at all. (J)

Health deterioration led to negative consequences on the partnership of one participant. Partners may grow more distant from one another physically and emotionally. The situation may be fuelled by the nature of some of the health deterioration symptoms such as pain, for example.

> The closeness is not there whereas (pause) in fact, you'd be, sometimes I'm frightened to touch her because I, I've gone to put my hand on her, and, "Oh, don't touch me there, it hurts," you know and this and that. So, you do, a person does tend to say, well, better not, I just give her a kiss, like I give her a kiss at night before I go to bed because quite often she doesn't go to bed. She sits up there all the time. (M)

Conversely, most participants viewed their relationships as drawing closer, becoming more intimate following their partner's health deterioration.

> So really it [wife's health problems] produced a closeness of both my wife and I and, and family too ... So in that sense it was a, it was a good thing. (R)

For those participants whose wives retained a relatively "normal" lifestyle post-treatment, life continued in a pre-deterioration fashion, albeit perhaps at a slackened pace. Other participants displayed an ability to transcend the intrusion of their wives' cancer and get on with their lives. In short, their lives did not revolve around the cancer or health deterioration. They adapted their lifestyles and incorporated whatever limitations were thrust upon them by health.

> She was sick and yet she wasn't sick enough to stay home or deny us the right to get into a vehicle and go wherever we wanted to was when we want to go. Ah, even on a cold miserable day when a person should've been - it wasn't fit for a dog - raining you know, we just had to get up and go, go for a little drive. Go into town for a coffee or coffee and donut or maybe a quart of milk. You know, just something to get out of the house and go for a little drive. (E)

> We don't follow other people. A lot of them are going to the old folks home but we're staying here and I think it is helpful to me to go out and work with, she loves flowers, she's planted them here for years and they're coming up every year and, the fact that her sight is gone, I wanted to stay here so that I could take her around and she could, even dimly see the flowers. It, it's good therapy for her. (T)

Husbands enjoyed the companionship with their wives, spending time with them. The point they emphasized was that they did not have to be "doing" something to enjoy one another.

> We like to be together, that's all (chuckle). Even if we don't need each other, well, we both still like to be together ... It's just like, I mean we, we sit in here. I mean I might do some puzzling and she might lay there and we got a record on and listen to the music ... Not always talking together ... Just, just togetherness is okay. (J)

Together with their partners, participants were often engaged in a wide variety of activities. Examples included: listening to music together, reading meditations together, praying together, playing games, watching television, bird watching and enjoying nature in their own yards. They also spoke of the number of activities they were engaged in as couples with other people. They did a variety of things including, for example, attending church and going out for dinner.

Thus, while all participants acknowledged that their wives' cancer diagnosis impacted them, the effects on their daily lifestyles at the time of the interviews were varied. For some, the status of their wives' health was negligible whereas others were markedly affected in negative or positive directions. Husbands of wives who had stabilized or improved were likely to remain actively involved with other people.

Prioritizing Marital Partnership

A number of strategies were employed by participants in dealing with the impact of their partner's health deterioration. They are subsumed by the strategy of "prioritizing the marital partnership." Indeed, this strategy parallels the main issue participants themselves identified in their lives: how they could best assist their wives in view of health deterioration. All other relationships assumed secondary status as husbands focused their attention on their wives. The increased devotion and time spent with their partners curtailed the amount of time husbands could devote to themselves. Particularly during more critical periods, thoughts of their partners overshadowed self concerns.

> I didn't [request prayer for myself] but I should have. You know, I'm just saying, I guess I had my eyes on her. (T)
>
> While my wife was in hospital two and a half months, my concern was her being in one place in one bed for two and a half months and what a miserable way that must have to be and I should be there and help her and try and comfort her. (R)

Decreasing Reciprocity with Others

In prioritizing the marital relationship, the husband's relationships with other people were also affected as illustrated in the following quotation:

> You more or less devoted to givin, giving your wife number one attention ... It's, over the years it's stopped me having contact with other people, other friends, you know (pause). Like, I've had numerous offers, oh, why don't you come over, come over and, come over and have a coffee, like you know ... I can't. (M)

Dependent upon the health of their wives, the degree of the husbands' reciprocity with others varied. In general, to compensate for the increased priority placed on marital relationships, reciprocity declined with others. While the overall thrusts of the participants' accounts were on their provision of assistance to their partners and the receipt of assistance from others, it is recognized that participants and their wives also provided assistance to others. It is important to bear this in mind as the predominantly one-way flow of transactions described below does not represent the complete flavor of relationships with others. However, as participants gave more assistance to their partners than anyone else, the greater emphasis on receiving support from others is an accurate reflection. It is consistent with the priority they placed on their marriages.

Assuming Responsibility: Caring for Wife

The strategy of prioritizing the marital partnership had consequences for husbands. The decreased focus on themselves was mentioned previously. Particularly in times of crisis, husbands, by their reports, diverted their energies toward their wives. In order to better represent the effects of health deterioration on participants, the marital level will be differentiated from the individual level. As indicated in the overview, there are many areas of overlap but the differences are instructive and the BSPP is best clarified by separating the two levels. The basic social psychological process integrates the levels into a "whole" again.

Reflecting the decision to prioritize the marital relationship, husbands formulated a strategy of assuming responsibility. At the marital level, the assumed responsibility took the form of "caring for their wives." Individually, the husbands' assumed responsibility encompassed "caring for self." As greater emphasis was placed by participants on their roles as husbands, the marital level is examined first.

Recalling the marital belief and marital history contexts within which the health deterioration occurs, it is not surprising that husbands expressed their resolve to remain loyal to their partners during the adversities related to health decline.

> As long as I'm strong enough and capable, I will do it. I'm not going to (pause) send her off to some seniors home or anything. She's happy here. She knows what she's eating and (pause), she knows she can get around as much as she needs to and (pause), she gets the care she needs from others at home and (pause), we're happy. (B)

The social context is also recalled in that some husbands were cognizant of expectations others had of them to care for their wives.

> Other people just sort of joke about it [assisting wife] with me. "Well you better get busy and do a lot of those things that your wife can't do now." ... Assumption is, well your wife hasn't been able to do it, you jolly well are going to have to learn to do it yourself ... I hope you've learned how to use the vacuum cleaner and know how to use all the rest (laughter) ... You're retired now, you can just fill in and do all those things that your wife did. (R)

Further, there may be a sense that no one else is readily available to care for their partners and therefore, even if husbands wanted to decrease their participation, they have little choice in the matter.

> What are you going to do? She's sick, she wants attention, you have to, you have to look after her, because nobody else will. (B)

The assumption of increased responsibility took different forms including increased participation in domestic duties and the provision of health care. As described previously, participants increased their domestic participation following retirement. For some husbands however, the rapid decline of their wives' health precipitated a sudden transition toward assuming the majority of household responsibilities. These husbands experienced considerable upheaval, whether for an abbreviated or extended period of time (depending on their wives' health status).

> It was turned around - like daylight and dark because I'd never written a cheque in my life. I'd never paid a bill in my life. Don't get me wrong, all the bills were paid. She was payin them all - she was lookin after the whole thing and I had to start writing cheques, in other words doin the cookin, the housework complete. From heavy equipment operator into a, into the house ... It ties, it's not, well 'tie' is a very strong word but, bein an outside person, construction all these years. It was quite a change to be tied in the house. Yesterday, I was outside [-30 C] layin under an old truck, workin underneath it. So (chuckle) I am not an inside person. (E)

In addition to domestic responsibilities, husbands undertook for the physical needs of their wives as much as possible.

> She slept in the other room because she made so many noises cause all the fluid on her chest. So, I kept checkin you know. Then I could see there was somethin else wrong. Here she was in insulin reaction. So I got her out here and got some of this sweet liquid I got from the U - from the cancer clinic so I got her out of that ...reaction, got her back to bed. (T)

The amount and type of physical care assistance varied considerably between participants, dependent in part upon the abilities of husbands and the health status of wives (and husbands).

> For the first couple of months she had a daycare nurse in once a week, you know with the bag [colostomy] assistin her on that you know. She picked up everything that had to be known about it and she done, done all that herself. She wouldn't, she wouldn't let me do anything like that. She looks after that herself, except goin down and all that for the supplies but that's the extent of my participation in it. (P)

> Tuesday, she had the last shot, and they send her home and she was just (pause), she was just sick, that's all. Got her home, had no bed pan, I had no diapers, I had no, no kidney bowls or nothing. I had to use towels and buckets and bowls and I had an awful time ... And I send out to the hospital, to the hospital drugstore to get the bed pan and some diapers because I had to use towels, she couldn't control herself. (B)

In addition to the readily tangible domestic and physical care responsibilities, husbands catered to their wives by performing a variety of other "minor" tasks. They aimed for providing little extras to help make things more comfortable for their wives. For example:

> I tend to be a bit more protective I guess. Assist her more. Help her do the things that she finds are a little bit difficult ... well, she has to get up at night to take a pill. Well I, I do that ...rather than have her stumbling around in the dark. (A)

Even under circumstances where wives were ambulatory and relatively healthy, husbands still expressed concern and a sense of responsibility for their partners. Participants devised contingency plans in the event of absences from their wives.

> But I always made sure that as soon as golf was over I went straight home to see that everything was okay, you know, and was with her for the rest of the day then ... I knew she was - that if she had any problem you know, she knew where, how to phone - she had a number to phone ... or how to get me, even to, at the golf course that if there was an emergency or even phone the hospital you know. Take a taxi down if something, emergency, emergency came up you know. But, so I didn't have to worry in that sense at all. (P)

> I was always close by, within earshot most of the time that if, okay, if I wasn't there [son] was home. Like that's the way it was set up that there was one of us around. But, most of the time, I guess 99% of the time, 90% of the time she was with me when I was gone. The only time she wasn't with me is, I'm a fanatic for farm sales, auction sales and she wouldn't come to the sales with me but I made arrangements them days for somebody like [son] or somebody would be close by or a phone number that the neighbors or some like you know. There was always somebody close ... after she had chemo, she had a hard time, the strength went all out, well not all out, it went out of her legs and it was always in the back of my mind that if she fell she couldn't get up ... if she ever fell on the patio or someplace like that, she'd be, you know, that I don't think she could reach the doorknob to ah, on the screen door like to let herself in ... we agreed that she would not go outside on the patio if there was nobody close by. (E)

The nature of the responsibilities assumed by husbands that have been presented thus far have been primarily instrumental. Domestic tasks and the provision of physical care needed to be done and husbands volunteered to assume responsibility. Participants left the impression that they were comfortable with their level of involvement in these areas. They were seemingly less comfortable on the whole with less tangible aspects of giving care; nam the provision of emotional support. There were considerable variations between participants but most expressed greater comfort with performing instrumental tasks.

> She says I don't give her enough comfort. That's probably right, maybe I don't. Maybe I don't (pause) cuddle her enough or something like that you know? 'Cause that's, that's really a necessity. They like to have attention, you know? Whereas I'm (pause) I'm, I'm, I don't know, I'm, I'm quite, I can do, I can be loving too. I'm loving too, but my main, my main thing is with me to, to be constructive. To do, to do other things, to get this. If I make tea, get her, "do you want something to eat?" She likes cheese on toast and all that and if I suggest that, she says, "yeah," so that's a, that's a help. I think I'm helping her by doing all this ... One day [wife's home care nurse] was here ... She looked at me and said, M, you're going to have to, oh, she done it to her, she gave her kind of a hug, you know. And I said well, I do, you know, I give her a kiss and all that, but of course (pause), she seems to want it all the time. (M)

Within the emotional realm, participants adopted an active rather than passive stance (e.g., listening). Husbands assumed "encourager" roles as they encouraged their wives in the face of hardships associated with disease.

> My wife in the beginning said, "why?" I said, "you can ask 'why' but you wouldn't get an answer anyway." I said, "you have to accept it." And now she does. I mean you have to accept it but you can pray for healing ... we pray for each other ... but if you don't get it [healing] I said we have to still accept it. (J)

> If she, if she gets down real low, I don't know about it because she'll hide it from me (pause) but at the same time, if I see that she's, a little (pause) low, I'll try to talk about the future. (A)

The provision of encouragement could become more emphatic on occasion, approximating "pushing." This was especially evident when husbands assumed a stance that the treatment was necessary for their wives' well-being.

> She said, "I have to go for treatment again." She said, "I, and I hate it." I said, "Yeah, well, you can say you don't take it," I said, "but you know you gotta." I said, "and you know the doctor says we can try to stop it [cancer], to put it in remission. I said, "and if you don't do it, take it," I said, "then you know for sure they doesn't get it in remission." ... "You have to take the treatment." (J)

> I'm concerned that she goes for her benefit, you know. I want her to go to get something done. So I get, I get anxious, and I say, "you've got to go," you know. [Clinic nurse] says "No, don't push her that way" you know ...

> Oh, gee, it's hard [not to push] because I'm (pause), there's nothing can be done, can be done unless she goes to that place [hospital], you know. I can't do nothing for her except feed her with pain pills which is out of this world what she, she consumes in pills. (M)

Some participants also felt obliged to assume an enforcer role over their wives' treatment regimen. They checked-up on their wives to determine compliance to physician orders (e.g., getting sufficient rest). While husbands did not force their wives to comply, they often exerted subtle pressure on their partners to do so.

In recognition of their wives' struggles, husbands attempted to infuse their partners with strength.

> Both my wife and I realize that psychosomatic medicine where the mind and the attitude is so significant to well-being, that if a person thinks they're ill and thinks their life is over, maybe it is over. Our physical [being] is affected by how we think, whether we're positive or whether we're negative. So it [diagnosis] called for very positive thinking and very great understanding. (R)

> I'm not a hard sort of a person but I'm, I'm direct. I, sometimes it might sound that I speak sharp but I don't mean to, you know. But I, I more or less tell her, in an ordering sort of way, not (pause) not really, not really the sergeant major style, not that, but I, I'm doing it for her. What I do, I do for her, you know, and feel that (pause) it's no good if I was in the same position, I would want somebody to, with strength, see I'm trying to put my strength into her by doing this, eh? (M)

Attempts to infuse partners with strength were often directed toward the development of more positive frames of mind in their partners. However, the desire of husbands to infuse strength and to appear "up" for their wives easily left them in binds. For example, they were uncomfortable dealing with emotionally-laden topics such as death.

> She frequently says, talks about dying, you know (pause). And really and truly, although maybe I'm wrong, I don't know, I tell her, "I don't want to hear that, don't let's talk about it" because I've, I suppose it comes out of me because I'm a positive thinker anyway (pause). And, I think you have to tackle a thing, never mind whether it's cancer or not. Like I said before, eventually it does get you, but right now, deal with it, the best way you know how. (M)

The topic was often steered from death toward projecting their lifestyles into the future, toward making plans for continued lives together.

> I even talk (pause), we even talk about winning the lottery, going on a world cruise, and all that, you know. There's nothing wrong with talking like that, you know, that's fine ... It's, see all these, all these little things, same as the travelling, go camping, and you go out on that, and you know, next year and all that, hopefully we will [go travelling]. (M)

Even if not discussed openly with their wives, husbands thought about death and the anticipated changes that would occur in their lives should their partners die.

> I have given it a bit of thought, like when I, I sat up there sometimes on my own, and thought well (pause), I've got [dog] here and one of these days it might be just what it is. I'll be looking over at that chesterfield, I'm sitting on the love seat, you know, and I'll be thinking, nobody there to talk to, human like, you know ... I don't really think of it in the sorrowful sort of way, I think of, I just try to imagine what it's going to be like ... What's it, you know, what's it going to be like then? (pause) Then I probably, then I tell myself well probably I'll (pause), I'll have the opportunity of going out if I want to any time, you know (pause). And getting on with my life, you know. (M)

While husbands considered the possibility of their wives' deaths, the topic was most commonly broached by wives (if at all). Except for the commonality of husbands avoiding the initiation of conversations with their spouses on this topic, there was no clear pattern concerning how this matter was handled by couples. If discussed by wives, husbands empathized with their partner's positions, sometimes thinking about how they would react if positions were reversed. Again, these thoughts were rarely voiced to partners.

> She feels that she's being cheated of her life. She, she has said on a couple of occasions, "I'm going to die," and I don't say anything ... She's hit me with that a few times that she hasn't seen this, hasn't seen that, you know (pause) which I try to, well, I don't really have to analyze it. I can, I know right away I can, I can detect what she's feeling, what she's going through. If I was in the same position, you know had a terminally, if I was terminally ill, I would probably think the same (pause) that I'm going to die, and I, you know, I want to do this, I want to do that. (M)

Other factors, in addition to infusing strength and discomfort with thoughts of death, contributed to the reluctance of participants to discuss death. Some husbands had philosophically accepted the reality of death and felt there was nothing to be achieved in view of the inevitable.

> Her feeling of, all this tiredness of it all that well, you know, "What are they going to find out this time? Am I really going to die now?" and you know, things that never were said before ... It's concerning, it's troubling. And I just say, "Look," I said, "we're all going to die one day." And I said, "look all these operations I've got coming up, I may not survive any of them." Who knows? We don't know but the more we talk about it the, it's not going to make it any better ... Change the subject, get on to something else and say look , you know it's, "you're the strongest one of the two of us by far, and if anyone's going to go that way, it's going to be me so now let's get on to another subject, talk about something else." (R)

Conversely, some participants, in recognizing the inevitability of death, viewed the topic as a natural topic of conversation. Spiritual beliefs facilitated discussion of death as an afterlife was believed to be superior to earthly life. Death was therefore not considered to be the final stage of life.

> We talk about it [death] sometimes. Quite openly. Well my wife says, "I'd like to get better." I said, "I'd like to stay with you for while yet" (chuckle) ... I said, "you will have it better here after" ... I don't [know] if I ever told you that story from that, ah, old lady was gettin on the bus. Could hardly make it up the steps. And the, bus driver said "boy oh boy," he said, "your best days are gone too eh?" She said, "oh no", she said, "the best is yet to come." (chuckle) That's what I mean. (J)

While shared spiritual beliefs could facilitate discussion about death, this was not a given. They could also relegate such considerations to silent ponderations.

> We never talked about it [death] at all because, I knew she was at peace with the Lord. I knew that. She was victorious ... We never, never went into things like that. So ah, I suppose maybe we should have but we never did anyway. (T)

Of those participants who indicated they had discussed death with their wives, most spoke of their forays as pertaining to pragmatic considerations rather than cathartic experiences. For example, the possibility existed that husbands could predecease their wives.

> We always talked from the first day she got sick or after she came out of chemo I guess, I guess that'd be that after death, before death, and you know the whole thing. We knew what the other person wanted like you

> know. She wanted to be cremated and her ashes in [location] and, she didn't want, she wanted a memorial here but none of her relations up here you see - just her friends ... it was a very open experience I guess you'd call it and it was something that we both felt at ease with, knowin that what the other person - see me with the old ticker gone and her with, with cancer you never know which is going to go first and we, like for her if I'd have went first she was selling the house and moving into an old age home or seniors home ... And for me, like I told her, I said well I'll keep the house if I, because I can drive but she couldn't you see ... what to do with the furniture and the house you know and the whole thing so there was nothing left - no stones left unturned. (E)

As evident above, the strategy of "assuming responsibility" covers broad territory. Participants were engaged primarily in instrumental tasks but their involvement varied considerably pending the health status of both participants and their partners. Domestic and health care responsibilities were voluntarily assumed by husbands, influenced in no small way by their contextual marital beliefs and marital histories. The expression of their responsibilities was also evident in less tangible ways as they encouraged their wives. Participants sought to infuse their partners with strength and positive attitudes. There were suggestions that in doing so, participants avoided more emotionally-laden topics such as death.

In assuming responsibility for their wives, husbands did not don dictatorial powers. Rather, they were engaged in a mini-social psychological process: "dovetailing marital resources." The emphasis is on "marital" because as indicated earlier, participants and their wives had maintained a history of self-sufficiency as a couple. That is, they strove to manage their circumstances as independently as possible.

Phase One: Dovetailing Marital Resources

The husbands' first phase in caring for their wives was "dovetailing marital resources." It was their preferred means of handling issues pertaining to the health deterioration of their partners. Participants identified three key resources that they dovetailed together in assuming responsibility for the care of their wives. The first, marital history, has been described previously as a context. Here, it is considered a resource in the sense that participants drew from their shared past with their partners to help shape their responses to current circumstances. The second resource identified by participants was their wives. Although wives varied considerably in terms of their functional abilities, even the most ill partner was seen as contributing in some way to the marital relationship. The third resource was each husband himself. Obviously, participants viewed themselves as resources in assuming responsibility in the first place. They considered themselves to possess many qualities that placed them in the best position of anyone to care for their wives.

Each of the three resources, as perceived by the participants, is described below. The mini-social psychological process, dovetailing marital resources, is then presented.

Marital history as resource. Marital history was presented earlier as a context and there is no need to repeat the information here. It is noted that participants viewed their provision of care as an extension of the pattern of reciprocated assistance from the past.

> It's not a one-way street. I'm sure it's a two-way street (pause). You know, if somebody, if you go in the ditch and somebody pulls you out, you wouldn't drive by and leave him in the ditch, like you know, so you return the favour. Marriage is a (pause) yeah, it's a 50-50, s'posed to be a 50-50, after 41 years it should be prit-in-near 50-50 anyhow! (E)

> We take care of each other ... That's why we got married for. For better and worse. (J)

Within their marital historical context, cancer was construed as another challenge, perhaps more severe than any other, but nevertheless as a challenge to be met like others in the past. Husbands could draw from their marital history of overcoming challenges together, of team work. Many challenges had been overcome with their partners and their past record of triumphs and failures could be drawn from to help guide the participants in their current circumstances. In this sense, the accumulated marital history was a resource.

> That's why I feel so sorry for people who are bachelors or spinsters, they have no knowledge of the great strength that comes from being together ... No marriages are really bowls of cherries or made in heaven. I mean, human beings what they are - we're very selfish, jealous people and it takes working together and be together and to work things out as they come along. And this kind of a trauma that results from cancer is just one of the more severe tests of a relationship. And the ability of those who are a party to the relationship to meet that traumatic challenge and use it as a benefit rather than a liability. (R)

Wife as resource. Participants recognized that despite their wives' deteriorating health, wives were not necessarily relegated to a completely helpless state. This awareness helped to discourage a mindset that wives were unable to do anything for themselves and/or others.

> Just because someone has a malady of some kind, be it as cancer or anything else, I mean it doesn't stop a person from giving and caring for others. (R)

Rather than being seen as "helpless patients," participants viewed their wives as resources; resources not only to them but also to the wives themselves. In regard to the former, participants continued to receive support and assistance from their partners. Wives participated in domestic tasks for example and some consistently acknowledged the efforts of their husbands, thereby enhancing the men's self esteem. Wives were also resources to themselves in their efforts to survive and to improve their own well-being.

Self as resource. In the discussion thus far, the participants' identification of themselves as resources has been implicit. Their personal sense of being in a position to contribute to their wives' well-being has been a common thread. Throughout their lives, participants had successfully overcome a wide array of challenges. Caring for their wives therefore became an extension of what they had achieved in the past.

> Knowing me all these years ... she's told me that, "you can do anything." Basically, I can, I do quite a lot of things, like there's, I have a very wide field of things that I can do anything with. If the television goes wrong, I can usually get it and fix it, you know. All kinds of things I do. Nobody ever comes in here to do anything for me, I do it myself. (M)

As noted previously, the transition toward assuming domestic and health care responsibilities varied widely between participants. For all, however, former skills were often applicable to current situations. Participants flexibly adjusted to their partners' circumstances as they drew upon their fund of common sense accumulated through the years.

> Nobody told me to let her stay in bed [only] an hour and a half or two hours or an hour, but years and years ago there was a lady, she had a nervous breakdown, and, she went to bed and she was in bed fer, I'd say six or eight months. You know they let her stay (pause), so I suppose maybe in the back of my mind it came that if she [wife] stayed in bed she wouldn't have the strength to get up. (E)

Most participants attached a sense of meaning to what had befallen their wives. Given the circumstances, some reframed the deterioration in a more positive light, deriving some beneficial impact in association with the losses.

> I think these things [life's challenges including cancer], when they happen, make us feel, you know, life is very precarious and today is a new day. Let's treat it as a new day. I mean it might be the last day. We don't know ... In that sense it's a benefit. The degree to which we know sadness determines how we appreciate joy. I mean if we don't have any sadness, how do we really know what joy is? I mean, you know, you, you've gotta have, you've gotta have a balance and you've gotta know both. (R)

> We're always praying, thank the Lord for one another, 'cause so many people are left alone. Look it, she's been, had cancer for 10 years, that's something to be thankful for, that she came through all that. (T)

Participants also gained self confidence and self esteem as they exercised their abilities in overcoming challenges associated with their wives' care.

> It [assisting wife through difficult chemotherapy], it gave me, it gave me great (pause) pleasure, and satisfaction to know that I could do it. (E)

Husbands therefore attached meaning to their implementation of new skills.

Dovetailing marital resources. In combining the three marital resources, participants engaged in a mini-social psychological process, "dovetailing marital resources." This was their preferred manner of handling issues related to their partner's health deterioration. That is, participants preferred to manage the situation within the marital relationship rather than cast outside its' boundaries for assistance. To help demonstrate this process, the area of domestic tasks will be reviewed.

Following retirement, participants increased their levels of domestic participation. There were greater efforts to divide domestic responsibilities more equitably than had been the case during earlier years. Husbands sought to assist their partners by working together with them in their h[illegible] the key word is "together" as participants drew from their marital historical context of teamwork and applied it to domestic duties. Participants also recognized their wives' abilities to contribute as much as possible (wife as resource) and personally supplemented their wives' efforts (self as resource).

> We do things together you know, like housework and all that - in that sense maybe during the years when I was working I always thought my wife's job was to do the housework and all that but now, like since I'm retired and all that, I've a lot of time on my hands so I, I don't mind washing dishes or, vacuuming the floors and things like that you know. Things that, she used to do you know. So, she appreciates all those things. (P)

The transition toward greater domestically based equality was not always smooth. Differences in standards between the partners could lead to criticisms and conflict.

> When we lived in the other place, and I was working at that time (pause), she kept the place spic and span. She dusted, she got up and dusted, and she was still, she was still in pain to a certain degree. I think she has deteriorated, you know, but you could, you'd come in the door and it would smell really fresh and look absolutely immaculate. Even people that used to come to the house remarked on it, you know, how clean it was (chuckle). And she is a fussy person anyway, so if the place is not the way she expects it to be, this is where I get heck about it, you know, all the time. Because, although I, I like to see a clean place, I don't, I don't like living in a pig pen, but (pause) my standards probably are a little lower than hers, eh? (laughter). (M)

The criticisms, if received, could at least partially be offset by acknowledgments from spouses concerning their domestic contributions. Indeed, acknowledgments were more plentiful than criticisms in most cases.

> Oh, I do get a plus for some of the things I do you know. She's a very private person. Now, if you look out the back, you'd see that we have an enormous deck ... And basically you're sitting up there, and it's like being on display, you know. And that's a no-no for her. She likes privacy and I understand that too, I like it too. So she wanted me to build something there ... I built, I got some, some of the trellis work, you know, and framed it and blended it in with the rails that we've got there, the deck, you know, and turned out to be quite good. Just the thing that she wants to give her the privacy ... 'cause she's got seats there and little table and she can go out when she can ... So, like I said, I got a plus for that. (M)

As described in the previous section, participants not only increased participation in domestic arenas, they also assumed greater responsibility for the health care of their wives.

> I'd let her stay in bed for about an hour and a half during the day and then up for about 20 minutes or half hour. Um, eats, forced her, I had to force her to eat whatever was possible for her to eat at that time and that

> went on for I guess about a week ... I let her sleep ... She wanted to sleep all the time. Of course, that was natural. But I, I didn't let her stay in bed anymore than I thought would be comfortable and healthy so she didn't get bed sores and bed ridden and so weak that she couldn't get out of bed. (E)

Clearly, the extent of their partner's health deterioration influenced the amount of responsibility assumed by husbands.

> Right now, it's even worse because she has to (pause), she has to have help, she has to have so much help, she just can't do it, you know. She's in too much pain to do things. (M)

The personality of the wife also influenced the amount of responsibility assumed by the husband.

> This is the type of person she is, if she had the choice of (pause), to sort of give me a break and go with [transportation service], you know, get picked up, go in [for treatment] with them, it's whatever, you know, she wouldn't, she wouldn't go for that at all. She wants me, all the time. She wants, anything, even, even when we go to the doctors, I have to go in there, like even that bone scan. (M)

The health status and personality factors in combination with increased responsibility in the domestic and health-care spheres affects the power balance between partners. Even if temporarily, the increased responsibilities assumed by participants creates power imbalances. In dovetailing marital resources, participants had to be wary of the potential for the marital resources to be heavily tilted in their own favour. That is, their marital history and wife resources could easily become overpowered by their "self as resource".

The participants were cognizant of the potential of their partner developing dependencies on them. They expressed discomfort with excessive dependency.

> She's thoroughly dependent on me. That's not a good thing ... I don't mind, I can handle it. I, I think of it from her point of view, it's not, not healthy, if that's the right word. It's not, you know, it's not the way it should be. (M)

Some dependency was expected, particularly during bouts of acute illness. However, participants were leery of dependencies continuing or becoming exacerbated over time and in dovetailing their marital resources, strove to enhance their partner's independence as much as possible.

Husbands discouraged excessive dependencies in different ways. For example, they did not step in to make decisions for their wives regarding treatment options, although they offered opinions if requested. In so doing, husbands demonstrated respect for their wives and promoted a greater degree of independence. Husbands encouraged their wives to do as much as possible for themselves as opposed to relying on them.

> She's got a wheelchair out there that, just these last few days, I said, well, why don't you (pause) instead of hobbling around, sometimes use the wheelchair. Sit down there and wheel yourself down to the toilet, or I'll wheel you. That's another thing, it's easy for me to just push it there, but while she can, let her do it, you know (pause) as long as she doesn't hurt herself ... Not that I mind, it doesn't mean nothing to me, just get up and push her down there, it's a cinch (pause). But to (pause) for her mind, to give her (pause) I mean, otherwise she's an absolute, it's the way she's going to think, I'm finished. I rely on him for everything you know ... If a person is, if you're doing too much (pause) it's, sometimes that can be as bad as not doing enough, you know ... That's what I'm learning. (M)

In a similar vein, husbands requested their wives to do things for them, thereby restoring greater reciprocity in the relationship.

> She's very, very willing to do things ... sometimes I'll call out for her to make a cup of tea, you know, whether I want it or not. (M)

Most participants indicated that in general, the marital resource dovetailing process was relatively smooth. However, one participant described bouts of great difficulty with his wife in their efforts to overcome challenges linked with her chronic health deterioration. Although his experience in regard to relationship cohesiveness was different than the other participants (i.e., he and his partner were drifting apart), he was still dovetailing marital resources. Distancing between the partners stretched his marital beliefs but not to the point of breaking marital commitments.

> The relationship is, it's definitely deteriorated, definitely. Even [home care nurse] noticed it because [wife] she's picking on, my wife is picking on me for, for stupid things that normally a person wouldn't do and I, I, although I don't tackle her with it I don't get back at her. It's quite obvious that she's taking out her frustrations on me, the one that's trying, trying to help and do things for her, and is doing them to the best way, the best way I can. She's even, you know, getting back at me. That's pretty hard to take, you

> know (chuckle) when you think, oh, I'm a good guy and I'm doing this and that and then, then you get booted for doing it. (M)

Despite the difficulties encountered with his wife, he did not consider abandoning her. The focus remained on maintaining the partnership.

> I just accept it [wife's criticisms] because I (pause) I suppose I don't want to upset her, you know? I suppose that's the way I, I'm trying to analyze myself now. I suppose that's what it is, yeah ... if that's what she wants, that's what she, that's the way it's got to be, because I, I mean, on the odd occasion when I've said, I definitely put my foot down, I said, "no, I can't do it, you have to do this and that," and then she, she throws it right back in my lap and says, "right, I'm not doing it then, I'm not going. I'm not doing this and I'm not doing that." (chuckle). I have no damn choice at all, no. Even though, whether it's convenient to me or not (chuckle), that's the way it is. (M)

Other husbands experienced difficulties as well and drew heavily on their marital history as well as themselves as resources to move forward. All of the participants vowed to do as much as was in their power to help their partners for as long as they were able.

> From what you see and hear that goes on, you can see there's people that couldn't care less what happens at home. But I'm not that way because, we toughed it out, we worked as a team right along, so, I can't see myself saying, well, homecare can look after her because I'm getting old and I don't feel like, I don't feel like looking after the wife, let somebody else look after her now. I will do, I will look after her as long as I'm, is capable. (B)

Even with the intentions and best efforts of husbands in dovetailing their marital resources, all realized that they could not manage within the marital framework alone, isolated from other people. Nor did they wish to do so exclusively of others. While participants and their wives preferred to retain the highest level of independence possible, participants were not adverse to receiving assistance from others. As described previously, husbands and their partnerships exist in a social context which both initiates and responds to the initiations of marital partners.

The strategies employed by participants in extending themselves outside the marital sphere are now addressed. This is the second phase of the overarching strategy of caring for their wives.

Phase Two: Accessing External Resources

As demonstrated thus far, participants sought to dovetail their marital resources in meeting their wives' needs associated with deteriorating health. While this was their primary inclination, they realized they could not meet all of the partnership needs within marital parameters. Participants were not adverse to seeking assistance but several conditions influenced their decisions to do so. The conditions (wife's health, husband's health, willingness to assist, availability, accessibility, unsolicited help, unsolicited unhelpful "help", and recognizing marital resource limitations) are outlined below and followed by a description of the "accessing external resources" strategy.

Since the participants in their roles as husbands is the focus here, this discussion will be limited to accessing external resources on behalf of the partnership and/or wife rather than for the husbands themselves individually.

Wife's health. The amount of diversity and fluctuations in the health of the eight women were presented earlier. Without repeating the discussion, it is noted here that the wives' health was also a condition influencing whether external assistance was sought. With improved health, husbands experienced relief and could, with their partners, resume a "normal" lifestyle.

> This radiation, there's nothing compared to chemo, like you know ... There's still a stress but it's nothing, it's nothing compared to, to chemo, for the simple fact she can get up in the morning, she has a shower, she puts her own salves on ... So, it is quite a, yes, quite a relief like, and there's no, there hasn't been a one, any one day that we couldn't get into the vehicle and go into town for coffee or breakfast or shopping. (E)

The women's health therefore influenced whether participants could manage their situations by restricting most interactions to the marital level. If the health declined beyond a certain level, participants were more likely to venture outside the marital arena for assistance from the partnership.

Husband's health. Comparable to the varied health status of patients, the husband's health status differed markedly. Health histories of participants were varied with four (M,T,P,A) having enjoyed good health throughout their lives. They were able to assume increased responsibilities with few difficulties following their wives' health deterioration.

> I'm probably just fortunate that I'm, I can do all this stuff [assume domestic responsibilities and care for wife] ... I'm well enough to do it. (M)

The health of the other participants was less positive. One (E) suffered a heart attack in his early sixties while another (J) had circulatory complications which developed following his retirement. Within the last year, he had also experienced kidney failure. Another participant (B) had a benign tumor excised from his gall bladder while in his mid sixties and had recently experienced pneumonia. The other participant (R) had developed severe arthritis in the past 18 months. These husbands experienced restrictions in terms of what they could physically perform.

> It bothers me - oh, I can't do that [yard work] anymore. I took great pride in that and I can't do it anymore. I still trim hedges and it kills me but I do it and I come in and lie down for about 12 to 14 hours because of this arthritis. But I do that. (R)

> I gotta be very careful, oh yeah, very, very careful, yeah, yeah. With the ole ticker I, like I can't go out and do anymore than about a quarter of what I used to do. I still pop the little nitro pills, even when I'm drivin a long distance I pop a few nitro pills and it settles down. Sometimes around the house here, I suppose you get thinkin of sickness and everything and then pop a couple of pills and everything settles down again. (E)

Health concerns came to the forefront for some husbands when their health prevented them from offering some types of assistance to their wives. Domestic tasks and physical care were provided until the husband's health presented a barrier to the continuation of assistance.

> She got into the bathtub and couldn't get up. I had to get up on the side of the bathtub like you know, and lift her up. And, that's when we, ah, went to home care. (E)

Continued care for a spouse when ill-equipped to do so could lead to deleterious results. Weight loss, sleep disturbances and other physical strains arose to some degree for participants. One identified financial strain:

> Like them bandages, I don't know if it's worth mentionin or not, they were, they were killin the pocketbook. Fifteen dollars a day for bandages and stuff and it, it's quite a strain there. Money-wise, money is a big strain when sickness, if you want to buy something and you just haven't got the money, it's a strain that you might want something for $20 and you only got $15. (E)

These strains affected the participants' overall health. Globally, the status of the husband's health is a condition influencing the decision to request assistance in the care of their partners.

Willingness of others to assist. The perceived willingness of others to assist was a condition influencing the strategy of requesting assistance. In most cases, the perceptions of husbands guided them as opposed to direct enquiries concerning whether others were willing to help them.

A common barrier to requesting assistance was the perceived potential of becoming an imposition on the source.

> I said to my wife, yeah well if we stay here [home] and well snow comes, [she] said, "you call one of the kids." But they have to shovel their own first to get out so then they have to come here yet, I said, and they can't do it whenever we want. No, [got] to do it when they can. (J)

Husbands sensed when they were near a ceiling in terms of how much more assistance could be requested from a particular person. Consequently, they grew hesitant in "going to the well" once again for further assistance.

> I can only go to church if (pause) the daughter comes and looks after her [wife] and (pause) she's here every Saturday and (pause) she has her own full time job so I don't want to push it. If she (pause) if she thinks she can make it, okay, but three or four times a year maybe. (B)

The participants' perceptions of the willingness of others to assist them was a condition to their strategy of accessing interpersonal resources. Obviously, if they believed a person was unwilling to assist, they were less likely to request help from the individual.

Availability. An additional condition to accessing external resources was the perceived ability of others to assist. Perceptions of availability were based on how people had responded to requests for help in the past. If people had been available in the past, husbands expected similar availability.

> He's [son] never refused to do anything for us. Me or her, you see. (pause) If I asked him to drive me to Saskatoon, Winnipeg, Toronto, no problem you see. If I ask him to do anything for us, he's, he's doing it ... no hesitation there at all. (E)

However, participants recognized that while past availability was a good predictor of future availability, it did not guarantee it.

> What's the use of dwelling on it [potential emergency] ... all it is, is I have to phone the home care and put it in their hands and (pause) and they have been pretty good up to now. I don't know what, with these changes [to provincial medical care] and stuff how that's going to affect anybody. (B)

Perceived availability was also linked to the offers of people to help. As will be described later, participants received unsolicited offers of assistance as well as invitations to socialize.

Accessibility. Geographical proximity in combination with the strength/weakness of emotional bonds within existing relationships influenced husbands in regard to requesting assistance from others. Related to the distance/closeness of the relational bonds was the perceived accessibility of people. The husbands' perceptions of a source's willingness to assist and/or availability did not guarantee ready accessibility.

> They're [children] all working, it would be pretty hard [for them to come if needed], because they'd have to take time off from work ... I had a good talk with a nurse from home care about that, and she says, well, things are changing all over the place. The best they could do was supply a 24 hour baby sitter, you might say, or something like that, or (pause) somebody to stay with her or something, if I wasn't able to. (B)

Some participants had accessibility to church member prayer support via prayer lines where one phone call by the husband accessed many others down the line. Generally, accessibility to people was facilitated by proximity. This was evident in descriptions by husbands in regard to their relationships with neighbors.

> I haven't had the problem but [neighbor] was sick one time and [other neighbor] took him to the doctor. Took his own car, drove him to the doctor, where he wasn't able to drive his own. So, I'm sure the same thing would happen here. Oh, I've driven him. One time his car ... wasn't working ... I had to drive him somewheres to, to his relative's place ... And I've gone shopping. He's asked me to pick up items like at Canadian Tire that he needed ... I mean, there's little things, but no, it is important to, to have a relationship with your neighbors, a good relationship because there's little things that, that are important. (B)

Another husband had a readily accessible source in his son because of their shared residence.

Medical services were generally viewed as readily accessible but the husband's perceptions of accessibility could be facilitated by the wife's physician(s).

> Like [wife's clinical physician] says, "don't forget the door is always open," you know, "day or night" ... It's a great relief that I, that I know where I can go 24 hours a day if something should, you know, if she should have an infection or something, you know. I don't know if infection works that fast or not but if it, she should get sick during the evening, I know that I can whip her in here and I know the phone number, I know the (pause) who to get hold of, like you know ... At least i don't have to start phoning and finding out who to, who to talk to, who, where to take her. Take her to a hospital, it'd be nice but then they haven't got her record. You take her to the [clinic hospital] here and they know everything about her, push a few buttons and they know exactly what to do. (E)

Accessibility to emergency health services and other people was mentioned by all participants as a source of continual relief. Participants were able to identify at least one readily accessible resource based on past interactions with the person and/or service.

Receiving unsolicited help. Recalling once again the social context, individuals and their partnerships can be the recipients of assistance without having to initiate the process. If it is perceived that sufficient support is being provided, the likelihood of specifically requesting assistance is significantly lowered. Receiving unsolicited help is therefore a condition affecting the strategy of requesting external help.

> They [friends] say, "well, if you need any help, just let me know then." But so far we did nothing, we didn't need it because the kids do it. (J)

Adult children were most often identified as the sources of unsolicited assistance. Indeed, the children were more apt to initiate contact with the husbands and wives than vice versa. Children often just "dropped in" or telephoned.

> I think they [children] might come more often now than they did before because they know that we are not so good so they come and, and have a look how we're doing ... We never ask them ... They come by themselves. (J)

By dropping in, children could become sensitized to the needs of their parents on the basis of frequent exposure to the couple. Under these conditions, husbands have less need to request assistance because help is being made available before they specifically request it.

> They [family] call and ask me if I need any help. The one [son] that did, helped me out [before] (pause). He's coming tomorrow and clean the roofs. (B)

> My son comes over and sees the wood box is empty and needs to be filled with wood, he fills it with wood or my daughter does or you know. I mean I, I don't go around asking [for help]. (R)

Unsolicited help also arose from other sources beside adult children.

> Last summer for the first time my wife's brother ... and his wife, came out to visit us after the operation. And that was the first visit we had from any of our relatives in the, in the 36 years that we have been out here ... They thought, you see, with this, with this, listening to me on the phone, the serious of the operation, you know - that, that she wasn't doin as well as I was sayin she was. So they thought they'd come out and see for themselves ... It was really good ... uplifting you know. Like after coming out from the hospital and all and she got, was lookin forward to them coming out too ... It gave both of us a lift you know. (P)

More often than not, husbands spoke of "we" in reference to the unsolicited assistance provided by others. People rallied to provide the couples with food and other demonstrations of their concern. Both partners benefitted.

> You get a good feeling that there are people who care. Some bring a bowl of soup and another brings some cookies and another one (chuckle) shoves a card under the door or they put them in the mailbox in church. (J)

> Our family is (pause), has rallied around pretty good (choked up). ... just being there - assisting. The ah, the program [chemotherapy] is very weakening, and the wife needs a lot of, assistance and they all provide that ... baths, laundry, once the ah, radiation was over, her strength started coming back and she was able to look after herself more. (A)

Receiving unsolicited unhelpful "help". The focus thus far has been on assistance, that is, on positive outcomes of interactions. With the exception of the earlier examination of undue dependencies and distancing that could arise within marital relationships, few negative connotations of relationships have been discussed. This reflects the oft-recurring theme of positive interactions reported by participants. Generally speaking, people met or exceeded participant's expectations.

However, no relationship is perfect and the potential for negative outcomes - unhelpful "help" - was sometimes realized. Participants did not describe negative consequences of interactions as deliberate attempts by others to harm their wives or partnerships. If some "help" was perceived to be detrimental to the partnership, other external assistance was sought or at the very least, the memory was used to guide future requests for assistance from the offending source. In this manner, unhelpful "help" is a condition affecting the decision to request external assistance.

Family, friends, and neighbors were seldom mentioned as sources of negative interactions. There were a few examples, however, of occasions where family members, seemingly trying to help, instead created discomfort or difficulty for participants.

> It doesn't really matter to me that they [son and family] don't come because (pause). It's, it's nice of them to come and, just for a short while I think, and bring, bring the little grandson along, you know, and all that, but we can't, we can't really, you can't really let yourself go, because, the atmosphere is, is not the same when you've got somebody that's ill, you know. It's (pause) all I'm thinking about is my wife all the time you know. She's trying to put on a front, be as nice as she can. All the time she saying to herself, I wish they would hurry up and go, you know. You know? Because she's, she's in agony ... I'm aware of it so it doesn't do me any good, yeah. So, I'd rather they, I'd rather just leave us to it. (M)

The provision of unsolicited "support" may be mismatched with the husband's perceived needs leading to perceptions of unhelpful "help".

> The family have, have, been too anxious I think to, to be available that, they have their own husbands and wives and, or husbands and children, and I've suggested that they pace things a little, little more so that they don't deprive their own family ... we've had, we'll say two daughters around quite a bit of the time, well, one's enough. I mean they, they could switch off a little. Out of four of them they should be able to, ah, make up their own schedule if they want - if they want, if they want to participate then um, but we don't need the help at this point. (A)

The receipt of such attention then becomes a condition influencing future requests for assistance (i.e., decreased contact).

Recognizing marital resource limitations. The primary condition influencing the husband's strategy of accessing external resources was the recognition of marital resource limitations. This condition is implicit in the conditions discussed above as without an acknowledgment of limitations in some capacity, there would be no decision to access external resources. The most obvious examples of limitations were in the area of health restrictions as described above (e.g., unable to lift wife). Limitations were recognized in other ways as well.

> She asks me a lot of questions that she wants answers from me and I can't. I said, "listen, I'm not a doctor! You have to go and see the doctor, get these answers." (M)
>
> She could see that I - it was just gettin too much for me I guess you know. So I had her here from the, right up to the - you know 2 weeks before she passed away. But there comes a time and place when you can't do anymore you know an' you gotta have extra help, you know. (T)

Acknowledgment of limitations did not seem to be traumatic for husbands, perhaps because they did not expect to be able to independently meet all of their wives' and partnerships' needs.

> I think that all you can, all a person can do is to try and, try and give, well, usually it's your spouse that you do it for anyway, give your spouse the best that you can possibly do for her, you know. And the doctor has to do the rest of it with all those pills or whatever it takes. (M)

Husbands maintained a desire to do as much as they could independently and did not consider seeking help to be indicative of failure.

Accessing external resources. Thus far, it has been demonstrated how husbands prioritized their marital relationship and in assuming responsibility at the marital level, employed the strategy of caring for their wives. In doing so, they dovetailed their marital resources as they endeavored to manage their health-related situations as independently as possible. This mini-process does not, however, imply that participants are necessarily resistant to external assistance. In the section immediately preceding this one, several conditions were reviewed that influence the husband's decision to request assistance from external resources. We now shift to the strategy of "accessing external resources" as this is the second phase in assuming responsibility for their wives.

Husbands had well-defined parameters around areas that they would request assistance for their wives and/or partnerships. For example, participants did not ask for money from their children. Although not always apparent, there seemed to be differences in the types of requests made of others on the basis of who the intended recipient was. Participants could differentiate their partners from their partnerships as the primary recipients of assistance.

As their wives' health deteriorated, husbands were often faced with new situations and therefore requested help specifically for their wives. These requests can be viewed as extensions of their assumed responsibilities for their wives.

> She had a big, big huge bucket and she, she'd heave up and it looked like, it was all blood ... And I thought, oh, I was calling nurses in. I was phoning nurses all the time to come over, you know, terrible that was. (M)

Requested assistance for wives took other forms as well. One participant contacted his out-of-town daughter prior to a scheduled telephone call for later in the day in order to alert his daughter of his wife's low spirits. He requested that his daughter try to cheer his wife up. Another husband alerted church members about the status of his wife:

> I'd always tell them you know, my wife's conditions. They'd get their prayer group to pray for her plus our own prayer group to pray for and then I'd phone L. and his group and they would pray for her. (T)

Husbands, in requesting assistance for instrumental tasks, could be seen to benefit directly in that they were spared from performing activities that for them would be too strenuous. It could also be argued that in requesting this type of assistance, husbands were asking on behalf of their wives as well because neither partner could perform the tasks. Other requests for help were more obviously made on behalf of both partners.

> When I come out of the hospital and I said, they told me no lifting for a month. No groceries, no nothing ... I phoned the nurse, and they came and they gave me what they call a saskapole post ... It's a post with a bar to it so she could get up. (B)

Participants could request help themselves in order to better provide care to their wives.

> The bottom of her feet was coming off, like you know in layers, and it was actually rotted, like the, you know, just green (pause). And when it first started that, I didn't know what to do (pause) whether to let it drop off or (pause) ... she [nurse] suggested that I take (pause) I can't remember if she said a blade or knife ... run it under the boiling hot water and then just trim the, trim the old skin off. That's what I done and that's what I continued to do (pause). I, I guess, otherwise I wouldn't have known what to do. (E)

Again, both partners potentially benefit from such a request for assistance.

Receiving Solicited Help

In response to their requests, husbands (and their wives) received assistance from various people in their lives including family, friends, neighbors, and/or health care workers. The formal network often targeted their services toward the wives but in the process, as discussed previously, could indirectly support the husbands as well. When solicited assistance was provided, it was most often directed toward the wives and/or partnership as a unit. Examples of the latter were evidenced when both partners benefitted more or less equally when their windows were washed or physical care was provided when both were ill. Both partners benefitted from the provision of marriage counselling, prayer support, transportation, house sitting, moving assistance, cleaning, cooking, etc. Assistance could take less tangible forms as well.

> My daughter ... likes to go there and hear exactly what the doctor says. She's there with the doctors and everything ... I've been with the doctors too. I know those doctors but, see my wife doesn't always understand all that strange language you know what the doctors use (chuckle) ... I mean our daughter understands that better and if she doesn't understand, then she will ask and then the doctor will explain it. See, we are not born here in Canada. (J)

Frequently, the nature of the support was premised on the health status of both partners.

> He [son who resides with couple] does the cooking (pause). Sometimes, well, I've had that cotton-picking flu for three weeks, so I didn't do too much either. But when I feel half decent, when [wife] feels good, we take our turns, like he'll do the cooking, I'll wash, she'll dry if she's up to it. If she's not up to it, I'll wash and I'll dry. (E)

The provider(s) of assistance could be anyone with whom the couple felt comfortable. For some couples, few providers were relied upon - reflecting limited needs, their discomfort with large numbers of people involved with them, the limited availability of others, etc. Other couples received assistance from a broader number of individuals. Providers could be family members (typically their own children rather than siblings), friends, neighbors, and health care personnel. Immediate family members, if available, were solicited most often and provided the bulk of assistance.

Even when satisfied with their present level of assistance, husbands could be concerned about the availability of assistance in the future. In order to preserve the level of assistance, they contemplated changes that may be required in the future.

> I feel, beginning to feel sorry for her [daughter] because she got married three years ago and (pause). Well, her husband does my lawn mowing and stuff like that. But, you know, they, they have no weekends. She's here on Saturday, every Saturday to do the housework, the laundry, and, and Sunday we're going out for brunch and (pause). Her life is very, very much tied in with ours ... She's never complained. She does what she has to do, what we ask her to, but, I realize myself that (pause). She, I think she'd like to have a little time to herself and (pause) with her husband, a little more time. Like, she's here just about every night to put the wife to bed ... She's younger, she can, she does it because she wants to but I'm sure that (pause) somewhere's down the line things are going to have to change. (B)

In general, participants reported that they were satisfied with the amount of help they received. In recognizing the receipt of assistance, they gauged whether more was required as part of the "dovetailing resources" process (to be described in greater detail later).

Receiving Unhelpful "Help"

Rather than solicited help emerging in response to requests for assistance, unhelpful "help" could result. Negative consequences were typically viewed as unintentional and could take the form of unfulfilled expectations or unexpected outcomes of seemingly well-conceived plans. As stated earlier, these types of consequences were more often associated with formal networks. Services could create unexpected negative consequences ranging from inconveniences to fears related with safety.

> It was a great help in a way because, it took, it took the house chores, like the floors and stuff, like you know, off. But ... as [wife] got, got better, it was an inconvenience. It took her, it took her home away. It took my home away. As I said before, she was in there scrubbing floors, of course I

> could understand that if (pause) I should have to be scrubbing floors I wouldn't want anybody to come in and, I realize that ... And I had to change, just the four hours (pause) which is no big deal (pause) But if you're like, if you're like myself, used to coming in any time at all and grab a half a cup of tea (pause) run outside with it and do whatever you're doing, to get out of the house, like you know to relax (pause). I s'pose it was a little inconvenient. (E)

> One time they sent a nurse in here when she [regular attendant] was away, that didn't, wasn't quite sure how to operate that chair in the bathroom. And she lifted her up, and she was going to sit her in it and the chair toppled over and she fell on the floor and fortunately, she didn't get hurt. But she, they never sent her again ... So that's the only bad experience we had and of course, she's quite fragile and she was very scared. ([illegible])

Some husbands experienced a more negative response than they had anticipated when they had accompanied their wives to the hospital. They felt excluded by health care personnel.

> I have always accompanied my wife, whether she's being, just having a routine exam, check-up by her surgeon ... I've always gone along, and always wanted to go into the interview room too with her. And it, while I've never been refused, I've got to say I've had a feeling, more from the nursing staff than perhaps the professional ... well, "why are you here?" You know, "you're not necessary" ... I think a woman appreciates the fact that her husband is very much interested in what's going on and I would think, ideally, there should be an encouragement, an encouragement should be shown by the health professionals, nurses and doctors, to almost ensure, well, "where is your husband? Is he interested in what's happening?" That should be part of the treatment. And, and it isn't. (R)

Husbands also described incidents involving their wives' medical teams that created undue anguish for both partners. In their view, the actions undertaken by the teams could have been avoided. Examples included unkept assurances of informing other doctors of medical opinions and test results. Missing patient files created time delays. Therefore, instead of helping, service breakdowns led to increases in the participants' work loads and strain.

> For her final shots they admitted her to hospital. But what else they done, I don't know because when she had the last shots, they sent her home and I was totally unprepared for her. She had the diarrhea. She was, she was throwing up. She couldn't walk by herself. I brought her home. I didn't get much help at the hospital either, I had to dress her myself ... And I was very mad at the hospital. I was very disgusted because she was not in a condition to come home. And the home care, they sent a

> home care nurse, she didn't come till Friday. And the home care nurse was very, she didn't say anything but she was very surprised, why did they send her home, because she said she was very sick, even at Friday, by Friday she was better! (B)

Husbands often increased their involvement rather than trust in the medical system completely, a further example of the increased responsibility they assumed in the care of their wives. One participant wrote to the patient advocate in the clinic as his wife's checkups and medication were inexplicably halted. He followed up this action further:

> I had to go to the family doctor to get back in, because they weren't, they weren't, because we were getting these appointments every three months regularly and they just stopped coming ... We waited three months, waited six months, nothing, what the hell's going on here? And especially after the doctor said that he could see, when he was doing her arm he could see cancer in her throat, and he took these extra pictures, he could see all these tumors. And he told the family, he said, "she's like a time bomb." He says, "she's going to go so long and that's it." ... And when the doctor, the doctor told us and here they cut us off the medication she's supposed to be getting. (B)

Other system limitations such as limited time availability for domestic and nursing services, for example, were noticed by husbands as well. In some cases, errors were made by the wives' physicians. Interventions with iatrogenic consequences, as well as misdiagnoses and overlooked symptoms, occurred on occasion. As a consequence of these errors, husbands experienced disappointment and frustration.

> The area that I have concern now is that they at the time said this is a different kind of cancer. It's a very aggressive cancer, type of cancer and ah when she came in on November with a complaint, then I think they should have looked a little bit closer at that complaint, rather than look at the general body. And I'm very disappointed that this happened this way because I do feel that ah, the cancer had already metastasized at that point because some of the indications that, that now, now present themselves more severely such as paralysis in the, in the face had in fact started by then and had, had been pointed out to the doctors here. (A)

> I was very concerned about my wife's well being ... I was very upset that this thing had taken so long, and of course, you know, in cancer you just don't wait because metastasis is taking place. (R)

Despite these negative experiences, most husbands continued to believe in the medical profession, even if less fervently. They recognized the imperfections as examples of human limitations and the limitations were weighed against evidence of competency. As a result, husbands retained large measures of faith in medical interventions.

> They're [doctors] endeavoring to do everything they can but ... they can't see through everything and they can't be perfect all the time, no more than I can. So, therefore I can't be a task master to them because I realize that I, too, fail in areas, that I don't always (pause) see through things, like you know, with an x-ray vision ... And that's life, you do your very best, you try to be diligent in business, whatever business you're in, but you, you know, you're going to come short one way or another. (T)

> I've enquired around with a few (pause) professional people and, from what I can glean this institution here is world class and you're not going to get any better. That is in, in the, cancer area, that, they know what they're doing. (pause) You got to put your faith somewhere. (A)

The illustrations thus far have pertained to the formal system, that is, the health care teams of wives. Of those participants that spoke of negative consequences of solicited assistance, references were predominantly of their experiences with formal systems, rarely with family and friends. This is not to say that all informal relationships were devoid of conflict or difficulties. Rather, it may be more of a commentary on the selectivity of husbands in soliciting assistance. They do not solicit help from those that have let them down in the past, those who have failed to live up to their expectations.

The solicited help and unhelpful "help" factored into the BSPP of dovetailing resources. As the BSPP incorporates the process undertaken by husbands at the individual level as well, this level will be addressed next. The BSPP will be discussed following the conclusion of this section.

Assuming Responsibility: Caring for Self

As presented in Figure 4.1, the process at the individual level mirrors that of the marital level in many ways. As just reviewed in the preceding account of the marital level, following the prioritization of the marital relationship, husbands adopted the strategy of assuming responsibility in caring for their wives. However, while husbands prioritized their marital relationships, participants did not completely overlook their own needs; particularly when their partner's health stabilized or improved. As discussed previously, husbands were impacted by their wives' health deterioration but were often unable to communicate this to their wives (i.e., the bind of needing to stay "upbeat"). At the individual level, husbands also adopted the strategy of assuming responsibility, but here it pertains to caring for the self rather than for the wife. They demonstrated care for themselves by monitoring their personal health, keeping active, and seeking respite.

Some of the participants sensed that they had to care for themselves because no one else could or was available. This recalls the social context described earlier and the general trend toward increased attention on wives by others. As will be discussed later, most participants were not completely overlooked by others but nevertheless, they received less attention from other people than did their wives.

In the first phase of assuming responsibility for themselves at the individual level, participants demonstrated their preference to use themselves as their own personal resources in dealing with the impact of their wives' health deterioration. However, as at the marital level, participants also sought assistance from external resources. Conditions influenced this strategy with most conditions operable at the individual level in a similar fashion as at the marital level. One difference from the marital level was that in the individual level of accessing external resources, spiritual resources were also identified. In the following discussion, all of the strategies as introduced above are presented.

Monitoring personal health. Participants discussed how they dealt with life events but self care was not always explicitly acknowledged. One exception to this trend was within the realm of personal health. As discussed previously, husband health histories were as varied as their wives'. In one instance, a husband's health had even deteriorated to a level below his wife's in terms of functional ability. While most participants were healthier than their wives, they were mindful of the possibility of developing complications themselves because they had experienced health difficulties in the past. If it happened then, it could happen again.

> You have to keep in mind that these things [personal health deterioration] could happen, especially after I had the (pause) pneumonia and a liver problem. These things could come and we have to be prepared. (B)

Other husbands only recently began experiencing health complications. For them, their difficulties served as a "wake-up call" to begin paying more attention to themselves.

> It's only since I've started to crack up and become a wreck that I've started to think about myself (chuckle) and the fact that I've been blessed with such good health all my life and never been in a hospital or never ill. Now all of a sudden everything's failing me. Better start keeping myself together (chuckle). (R)

In addition to their own desire to be healthy and avoid becoming "invalids," husbands recognized the necessity of maintaining their health in view of their wives' conditions. For those husbands of wives with limited functional capabilities, their own health status carried a greater premium as more was at stake. Their way of life would be threatened if their health declined as their wives were unlikely able to care for them. Therefore, participants had greater incentive to care for themselves.

> If I'm not healthy then, who the heck's goin to cook? (pause) We're going to phone home care or somebody to make a sandwich? (B)

Participants were generally aware of their health-related limitations and did not push themselves beyond them. However, in times of crises associated with their wives' health, marital responsibilities took precedence (prioritizing marital partnership). Husbands often placed their wives' needs above their own and consequently, they sometimes needed to be reminded by someone else that in so doing, their own health could become jeopardized.

> I got to go see my doctor this afternoon too ... Pneumonia, that's what he figures I might have. I should, he told me "you should have been here two weeks ago." Well, I was too sick to go two weeks ago (chuckle) ... I told him I was takin [wife] for radiation, and well he says, "if you don't get in and look after yourself," he says, "who's going to drive her if you get sick in the hospital?" Good question. Good question, yeah. So, I'll go in and see him this afternoon and, it just a great possibility he might put me in for a few days too. I, I really don't know ... I figured I can pull it through, like you know and then (pause) as long as I don't get any worse, like you know ... I had the feeling he'd ground me ... We finished on the 3rd and then I went in to see him. (E)

For other participants, the need to care for themselves may not have been as physically evident. The effects of their wives' long-term hospitalization, for example, could be more subtle and unless encouraged to step back, husbands could be unaware of potential personal health costs associated with prolonged disruptions in daily routines.

> My wife used to tell me when I was down there [hospital] at night sometimes, "you know," she'd say, "why don't you go off out to a movie?" Or "why don't you go out?" and I just say, "well no, I want to be here with you." And she says, "well you might be better off if you went off to a movie" (chuckle) "or went to visit or just had accepted that invitation to go to the J's" ... I was probably played out and my wife was right, why didn't I do something that gave me a little (pause). But I just hadn't thought that way. (R)

Apart from crisis situations such as those above, participants usually attended to their own needs. While they assumed greater responsibility for their wives, husbands did not generally forsake their own needs over the long-term.

> Certain things you have to do yourself, too, like I painted the fence to do something positive to keep my mind on something positive you know, and I had to (pause) well, you know, I had to keep up the self, it's a good thing to have something to do, to do the lawn and take care of the flowers and things, and I'd go up to the hospital to visit my wife. So, you know, having something to do is not the worst thing in the world. (T)

> I've been able to retain activities that I want to do. Now that we've got into (pause) knowing what's in store, day to day, [wife] can go to sleep or something, I can go out (pause) and there, there's really no severe limitations on my activities ... I work in the basement, fussing around (pause). Go out to lunch with a few of the people and things like that. (A)

It is apparent in the immediately preceding illustrations that husbands gravitated toward a strategy of keeping active as a means of attending and caring for themselves. This was a common experience between participants.

Keeping active. Participants strove to maintain as active a lifestyle as possible. Activities were as physically oriented as their health permitted and included a wide array of activities such as yard work, construction, painting, woodworking, mechanical work, housework, and puttering around the garage. Generally, these types of activities (as well as other less physical activities such as working on photo albums and listening to music) were solitary. Fewer socially oriented activities were described in total but again represented numerous interests. Examples included bowling, golfing, singing in choirs, and involvement in club or church organizations. The perceived self-care benefits derived from the types of activity pursuits were diverse.

> Working, doing things, that always has been a thing with me. It's, it's a form of relaxation (pause) even though it's [building a garage] hard work, it's still something you're doing for yourself. You want to do it, you know. You're not doing it for somebody else, you're doing it for yourself because you want it and you (pause) of course, you get, a person does get pleasure out of the results. (M)

> I have certain business things that I was involved with. You know my RRIFs and stuff, kept my mind in a positive way you know what I mean? It's no use in getting into a negative thing, you know what I'm talking about? That doesn't help anybody you see. You have to be positive in your outlook, you know. (T)

Generally, activities were extensions of life-long interests. In participating in them, husbands maintained their lifestyles and cared for themselves.

> I never had any really stress. You know, you go through a little - you worry a little you know but not - but it wasn't stressful that, that I couldn't cope with life or anything like that you know. As I said like last year I went out golfing every morning and even after the operation and all that you know. (P)

When their health intervened and prevented normal activity levels, participants redirected their energies to other interests.

> I listen to my music a great deal which gives me a lot of satisfaction, but my arms and my legs (chuckle), no, I can't do much of anything. That's a real disadvantage right at the moment. Well has been for the last 18 months. (R)

The desire to maintain as active a lifestyle as possible was consistent with the husband's concentration on the provision of instrumental assistance to their wives. Engaging in domestic and physical care activities were closely aligned with their desire to remain as active as possible. They were comfortable assuming such responsibilities to the degree to which their health permitted.

Seeking respite. As reported previously, most participants acknowledged some degree of strain associated with the deterioration of their partner's health. If possible, they sought respite as a means to care for themselves. Participants typically sought breaks whether their wives' deterioration was chronic or acute.

In the former circumstances, husbands seized opportunities whenever possible or scheduled time off on a regular basis.

> She wants to relax whether it's up on the chesterfield or whether it's going to bed. So, I'm quite happy for her to do that, to be quite honest because that gives me a break too (pause). So as long as I'm out there [working on garage], I can concentrate on what I'm doing knowing that she's having a rest. (M)

When the conditions of their wives were acutely serious, husbands were less likely to seek respite. As their wives improved, however, they would begin to leave their partners for brief periods of time.

> I was able to get out, like there was about three weeks, I'm not cryin now but there was about three weeks I, I couldn't leave the house. I, I didn't feel safe of leavin the house at all. And then, as she got better, then I'd leave the house for an hour or two hours or you (pause), just to get out, like you know, and on my own like a little bit. (E)

Other wives were neither chronically disabled nor in an acute health care crisis. They did not need continuous supervision and as a result, husbands were able to get away more freely. These husbands nevertheless found it was still important to have some time to themselves.

> You know it broke the monotony or whatever it was like you wouldn't be sittin beside her for 24 hours a day or anythin like that you know. Like, she wanted me to go out ... she wanted me to not just sit around. Wanted me to - send me out shopping or something like this ... I did grocery shopping. That'd take up maybe an hour or two and, so, and out golfing. One thing or the other and then I had all summer to cut lawns and cut hedges ... So between the flowers and cutting lawns and cutting hedges, that and my golf game it took up - and lookin after her you know ... I got new sidewalks put in last year which are wider so there's a lot of snow to shovel off them. And, so it just keeps you going you know. (P)

While husbands were able to physically remove themselves from their wives for short periods of time, they were not always as successful in completely distracting their minds from their wives' situation. They often remained mindful of their responsibilities while away. For example, the need to return home on time to administer medications required one husband to be mindful of the clock. Another reported his preoccupation in the following way:

> It was relaxing, to know that there was somebody [home care attendant] there (pause), but I couldn't get away from the house down to the

> neighbors or some place (pause) and relax. In case something did happen. (E)

Thus, when their wives were more seriously ill, husbands were often unable to "escape," even if physically absent form their wives. They "remained on duty."

The three stategies for self-care described above were demonstrations of assuming responsibility for the self. Comparable to the marital level, participants maintained their assumption of responsibility for themselves through two phases. Both are presented below.

Phase One: Using Self as Personal Resource

In assuming responsibility for their own well-being, participants displayed their preference to manage as independently as possible. This preference paralleled their intent at the marital level to manage as much as possible through utilizing their marital resources. At the individual level, husbands worked through their struggles associated with witnessing health-related losses in their wives in a manner consistent with how they had dealt with previous upsets and losses in their lives. More often than not, it was done on their own.

> When I talk to them [children] on the phone, see I don't show anything. I'm so, I think I've always been like that, even, okay, right throughout your life you go through tough times, financially and other ways. You lose your job, you get laid off, no work, this, that you know. I've always been able to swallow that myself and make it look rosy, you know to my wife. I always had that talent to do that, even though inside, I, "geez, what am I going to do?" you know. (chuckle) ... I guess they [children] just know what I'm like and handle things, I suppose, I don't know. (M)

> I think a person should, should let it out, let out, cry. It doesn't matter how old you are. It's a great relief. [Researcher: "And you've been able to do that with one another?"] No, not in front of one another anyhow. I don't know if she cried or not. I went out in the shed and I've, I've let a few tears out, yeah. (E)

Thus, participants utilized themselves as their own personal resources in dealing with many current difficulties, continuing their preferred mode of handling problems.

Phase Two: Accessing External Resources

As occurred at the marital level, husbands recognized that they could not indefinitely manage independently. In assuming responsibility for self-care, participants also engaged a strategy of accessing external resources. This strategy is affected by several conditions, most of which are similar to the conditions identified at the marital level. The conditions are: wife's health, husband's health, willingness to assist, availability, accessibility, self disclosure comfort, indirect support, unsolicited help, and recognizing personal limitations. Each is presented below.

Wife's health. The fluctuations in the health of wives has already been discussed. This condition influences a husband's desire to access interpersonal resources in that if his wife's health is stable or improved, there are fewer demands on him in terms of coping. One participant commented, for example, that he had experienced little stress post-cancer diagnosis or post-treatment as his wife was able to maintain her usual activities. Obviously, if the health status conversely deteriorates and a husband experiences coping difficulties, he is more apt to seek personal assistance. As noted previously, participants were more likely to seek help of this nature from informal sources than formal sources.

Husband's health. In the previous discussion of "assuming responsibility - caring for self," the area of personal health was covered in considerable detail. For several participants, health became a "wake-up call," alerting them to the need to care for their bodies; bodies which they had more or less took for granted formerly. Personal health deterioration was often a condition to requesting personal assistance from interpersonal resources - usually from the formal network but also informally through requests for assistance in laborious tasks.

Willingness to assist. At the marital level, participants believed that other people were willing to assist their partners and the partnership. One of the means by which they developed this perception was through fielding offers of assistance from people with whom they had relationships. Fewer offers specific to husbands personally (apart from the partnership) were received but participants indicated their sense that other people were willing to assist.

> Well, in a pinch, you know they [neighbors] will help. (B)

Participants with spiritual beliefs extended this further as they believed God was willing to help them personally. The perception of a resource's willingness to assist influenced whether the specific resources would be approached for assistance.

Availability. Participants identified their perceptions of the availability of others to assist them in some capacity. If an individual had been available in the past, it was assumed (but not guaranteed) that future availability would exist as well. The perceived availability was a condition therefore to requesting personal assistance.

> There's a few other people that I can phone up and I can talk as long as I feel like talking on the phone. They've never been to the house, never will, I s'pose ... (pause). That's, see that doesn't matter ... You feel comfortable. (E)

Accessibility. In the illustration above, the identified friends were not only perceived to be available, they were reasonably accessible - via the telephone. For those identifying God as a personal resource, accessibility was achieved through prayer. Accessibility to resources apart from the self was a condition to requesting assistance from them.

> If we need any help we just have to let them [children] know and they are here. (J)

Self-disclosure comfort. As described previously, participants were comfortable requesting assistance on behalf of their wives and/or partnerships. In regard to their personal needs, it will be demonstrated later in the discussion of "accessing resources" that there was greater comfort in seeking instrumental help than personal advice or emotional support. One condition particularly relevant to the types of requested assistance is the level of self-disclosure comfort. How willing are participants to ask for help in more personal, intimate areas of their lives? If the discomfort level is judged too high, it is obviously less likely that husbands will request personal assistance.

Each participant had his own comfort level in regard to the amount of personal information he self-disclosed. Most participants rarely disclosed personal information about their experiences to anyone. For the most part, they were uncomfortable with unburdening themselves to others.

> We have a membership in church ... but most of the people are from different places and different lifestyles and different habits and they stick to themselves and, you really have to get into it, get intimate to find out and, I'm not the type that will dig in and dig into their private lives. If they want to (pause) generalize, they can generalize with anybody on any

> topic but you can get the specifics, like your home life and (pause) if he has any problems with his wife or anything, you don't talk about things like that. (B)

A few husbands were more open, exchanging information of a more personal nature.

> I've never been one for a cocktail circuit where you talk about the weather and you talk about nothing. No, if I'm talking to somebody I want to talk what I would hope is substance. Either about what's bothering them or concerning them. Have they got problems in their business and if so, can we talk about it to help and (pause) but not just a little chit chat about nothing ... I'll want to find out who they are, what they do, where they come from, why they're doing what they do. (R)

Topics of conversation with most people that participants had relationships with were of reminisces and general areas apart from personal matters.

> We [neighbors] don't get into family matters. You go out there, you talk about the weather. You talk about politics and that's about it ... I'm not going to talk about personal things. Talk, talk generalities. (B)

Some participants disclosed little, if any, of their personal experiences with others outside their marriages. Some described their partners as their only confidants while others noted they had a few friends with whom they could unburden themselves.

> I've (pause) two or three friends that I, I do (pause) I can unburden myself to them, you see. So this is, I think everyone really needs someone like that, you know what I mean? (T)
>
> They'll [friends] know things that I, that I tell my wife. She'll say, "what'd you tell them that for?" you know. I mean (chuckle), "that's our private information." I don't feel that way (chuckle). (R)

Husbands may not disclose personal information for reasons in addition to their personality characteristics. For example, it was discussed previously that adult children in particular are apt to drop in on their parents fairly regularly. Husbands may not voluntarily express their personal experiences because they believe others, who see them frequently, can simply tell how they are doing by observing them. Therefore, there is little perceived need to request assistance.

> They [family] know us pretty well. I mean, and they know how we feel about each other so I don't think we - they don't ask special how you cope with it. They know how we cope ... They can see it. (J)

> They [children] all pretty well know what's going on with me. I, I don't keep any secrets. I mean, with the family, they know so well, so who else am I going to tell? I don't, I'm not that outgoing to talk to every man I meet on the street and tell what my problems are (chuckle). (B)

In other instances, husbands may be reluctant to disclose personal information and request assistance because of their perceptions of how an individual will be impacted by such information.

> He's [friend] a very sensitive man. He's lost his mother of cancer and when [wife] first got cancer and I was talkin to him, he got tears in his eyes, after this many years that his mother passed away. So I didn't, I respected his sadness ... We touch on the subject but we don't dwell on it ... Other things like we can yak about old car bodies, old junk steel, wood, anythin like that we could dwell on that for, talk about that for two or three hours but mention sickness and, he just, he doesn't walk away but you can tell when a person doesn't want to talk. (E)

Husbands weigh the merits in sharing personal information with the perceived costs to themselves and the potential recipient. In general, the level of current self-disclosure seemed consistent with past levels of self-disclosure. As noted previously, husbands who identify their wives as their confidants may find themselves in binds, unable to confide in their wives (concerning matters related to their partners) out of the desire to "protect" them. Under such circumstances, husbands rarely sought other people to confide in.

Indirect support. It was previously demonstrated that wives were often the recipients of assistance from other people within both formal and informal networks. Under such circumstances, when wives are specifically targeted, husbands can also experience support. Because they were not the intended recipient of support (as determined by the husbands), their perceived support is "indirect support." This phenomenon influences requests for assistance from others in that if husbands receive sufficient support indirectly, they are unlikely to seek further help.

In previous sections, the amount of attention directed to wives by others was described in relation to the social context. Participants, for the most part, professed comfort with responding to the enquiries of others.

> You know that people care. They really like to know how things are going ... for me it is no problem ... You go to church and you see ten people and then ten people ask me, you have to tell all of them the same thing ... It doesn't bother me. (J)

Husbands gained a sense of connectedness and confidence when others performed some act intended to assist their partners. They did not feel as isolated in their experiences.

> I know they [church friends] were praying for my wife ... I had a friend of mine, he was a pastor for twenty years ... He had a stroke the other day, they took him down to the hospital and his wife went down and got the pastor and they went over and he anointed him with oil. And, you know, his daughter phoned up these twenty, or different churches that he was a pastor of, and they started praying for him. This is the power of prayer, the next morning when the doctor checked him at the hospital, there wasn't a thing wrong, and before that they said the whole side was paralyzed that evening before. Now that shows the power of concentrated prayer. So, I'm just saying, you know (pause) that's the kind of people I have praying for my wife ... It gives you confidence you see. (T)

> I don't suppose it's the idea of the long talk. It's just the idea that he [wife's brother] phones to find out how she is ... I suppose it shows that there's somebody more than me that's, concerned. (E)

This secondary benefit to husbands was also evident in light of the health-care services received by wives (usually in response to the wives' requests). Not surprisingly, these services were primarily directed toward wives - the patients - but the provision of services often provided husbands with peace of mind.

> She [wife] had different company with her, and she could, woman to woman, like you know. See we gave the lady [home care attendant], well we didn't give her (pause). We, when she first came we told her that she would take a half an hour off that time to sit down and (pause) gossip. That was a must ... If she didn't do the housework, I didn't care ... I s'pose after the conversation, she'd go back to bed. I don't really know because I was outside ... It was relaxing to know that there was somebody there. (E)

Indirect support perceived by participants tended to encompass the emotional realm and influenced whether participants requested assistance of this type from others. That is, if husbands got their emotional needs met in this indirect fashion, it was unlikely that they would request as much emotional support directly.

Unsolicited help. With reference again to the social context, it is recalled that other people can initiate interaction as well as respond to requests. The condition of unsolicited help refers to the initiatives of others to focus on the participants as individuals and in reference to their situations. Depending on the amount of unsolicited help, husbands may not need to specifically request assistance because their needs are already being met.

As noted earlier, attention from others was usually directed toward the wives. Some participants, however, received personal enquiries into their own well-being. These enquiries represented concern for their welfare and were perceived as helpful. Most often, questions pertained to physical health; there were fewer examples of enquiries related to the participant's coping abilities in conjunction with their partner's condition. When enquiring about the husbands' status, people tended to tack questions on to enquiries about their wives' status.

> There are people come up to me and then they ask, "how is [wife] doing?" I say, oh (pause), I guess what happens. And, and then they say, "and how about yourself?" I say, "well I'm doing alright." (J)

It was not uncommon for "enquiries" to take the form of observations or statements.

> They [friends] used to say, "you're looking alright." (P)
>
> I've had people, I've had people praise me for it [providing assistance to wife]. I mean, I don't look for the praise, but I've had people praise me ... "You do, you do a lot , don't you?" I said, "oh, yeah, it's nothing." (M)

On occasion, husbands fielded enquiries specifically regarding how they were managing with their wives' situation.

> There's always somebody that will come to you and if I happen to be on my own or something, then ask how my wife is or ... they'll ask you how you're copin with it yourself or how you're dealin with it, you know, or feeling, you know. (P)

Upon fielding an enquiry of a personal nature, most husbands felt uncomfortable and/or responded superficially ("I'm okay"). There was often a sense of unfamiliarity, even bewilderment associated with being the focus of attention.

> On the odd occasion they'll [children] do, "how are you doing Dad," you know, "you all right?" "Oh sure, I'm okay." Yeah, I found I really don't know how to answer their questions. I, sure, I'm okay. I think they're asking about my health, you know. (M)

> Sometimes they [church friends] would ask how you're bearin - handlin yourself. A lot of people did do that as a - especially at the church I got that ... I used to wonder why did they? I used to remember I'd often look in the mirror when I go home and think I wasn't feeling well or something when they would ask me that question you know. But then my wife said well probably it's because maybe they think you're stressed out or something like that you know. (P)

After realizing the intent of others in enquiring, participants tended to view the enquiries favorably and as helpful.

> I thought it was very nice of them - the person to inquire about it ... It made me feel good. (P)

Unsolicited offers of assistance or invitations to socialize were also directed toward participants on occasion. These offers and invitations were further acknowledgments of the participants' situations.

> She's a widow lady but, oh yeah, not so young anymore but she said, "if you need anything done just call me." She said, "I'm right next door." (J)

Some husbands preferred that unsolicited attention be directed toward their partners rather than themselves. This reflected the priority they placed on their partners.

> I, I've found that, I get enough [attention from others] and it should be directed to the wife, not to me ... maybe I'm a little careless but I don't feel I need it ... it's not uncomfortable, it's just ah, that I guess I have an overwhelming concern [for wife]. (choked up) ... Oh, they're certainly appreciated and yeah, they're appreciated ... But ah, I don't need it. (A)

Unsolicited help from people also took more instrumental forms. For example:

> My wife was praying for me, too, and my friends, you see. So this is what it is when you have Christian friends who will pray for you, for in, in your trials, you see, you're not alone with it. (T)

> Some of them [friends] have set up meetings with knowledgeable cancer people which weren't really solicited but they did it anyway just to

> (pause) reassure me I guess, that this is a good institution. (pause) And it, the people at the (pause) they arranged the meeting with did a, went a long way towards assuring me this is a good place, that you don't really have to go down east or into the States. (A)

Some participants, whose wives had suffered debilitating losses in their functioning capacities, identified the boosts they had received from health care professionals who had recognized their efforts. The assistance they received from these sources was not in the form of instrumental services but rather, emotional or esteem support. For example, one husband received the title of "honorary nurse" from the home care nurses attending his wife:

> It was just a word title, it wasn't anything on paper, it was just a, but it made me feel good that I knew how to bandage and look after her as well as they did and with, with no training. It made me feel good that they couldn't show me anymore than I already knew. So I s'pose that was, I s'pose that was quite an accomplishment, in its way, like when you, when you use about $15 worth of bandages a day, you got to, you got to learn pretty quick that you don't spend $30 a day (chuckle) ... Them giving me a compliment like that, I'd, yeah I'd put another hair on my chest. Or feather in my hat, or something like that, yeah, so it was quite an uplift. (E)

Another was acknowledged for his efforts by a clinic nurse:

> I get the picture that [clinic nurse], she's, she's well aware of the (pause) the situation although I haven't discussed, I haven't discussed everything with her. But the way, the way she talks to me, that, she gives me a lot of encouragement, tells me I'm doing a good job. I don't know what I'm doing, but whatever I'm doing must be right. (M)

Again, the receipt of such assistance influenced whether husbands requested additional help.

Recognizing personal limitations. The primary condition influencing whether a husband sought personal assistance was the recognition of personal limitations in a specific area. This condition is implicit in the conditions above. While husbands strove to do as much for themselves as independently as possible, they were not adverse to requesting help from others when they perceived limitations.

> If I need help, I, I, I'm not backwards in asking. I feel quite comfortable, or quite comfortable in asking anybody (pause) for help (pause) if I need it ... If I think I can do it myself, I will not ask for help. (E)

Accessing external resources. The above conditions were influential in the decision to request personal assistance. As stated previously, participants were not adverse to asking for help but their preference was to do as much as they could for themselves. As will be evident later, the strategy of accessing external resources was also evident on the spiritual plane (for those with spiritual beliefs). In regard to interpersonal relations, participants were generally satisfied with the amount of contact they currently had and infrequently sought to expand the number of relationships. They were satisfied with the "raw material" of their existing relationships. For example, one husband had few relationships outside his family, yet was content. However, another husband, with limited contact with others, sought more interaction because he had recently moved and wanted to learn more about his new community and residents.

Differences were noted in terms of the specific types of assistance requested by husbands. In general, if they requested personal assistance, it tended to be related to instrumental tasks for which they were ill equipped to perform due to health and/or ability restrictions.

> [I] get somebody to cut the lawn for me and (pause) help clean the garden and (pause) well, help to clean it off, and he [son] dug it for me. And little things I can do. Winter time I get somebody, heavier snow fall, I get somebody to shovel the snow for me. (B)

Participants also asked for advice in areas they lacked knowledge; usually pertaining to their wives' physical care. Husbands were relatively at ease in acknowledging their needs in these areas. Sources of requested help were varied and included family, health care providers, neighbors, and to a lesser degree, friends.

Participants rarely directly requested personal emotional support or advice for themselves regarding difficulties they faced in light of their wives' condition. Perhaps this stems from viewing these types of help as unnecessary or unhelpful.

> Like in the church ... when my wife was ill I would bring up the prayer for my wife or something like that, you know, was ill or was recovering from cancer or something like that. But no I've, I've got the strength I believe and I don't think there was any necessity for it [requesting prayer for himself]. (P)

One exception to this trend was noted:

> When this incidence of difficulty between my wife and myself developed, my wife, unknown to me arranged to see [psychologist] and then she mentioned it to me. And I said, well, goodness sake, let's see her together. So we saw [psychologist], she saw me and then she saw my wife and ... she's going to see us together ... I haven't got any built-in inhibitions here. I guess, in a way, it's a, I kind of enjoy, as you may guess in talking to me, I kind of enjoy the, the discussion between people on these things. I think it's, I think it's very important that we talk about these things. (R)

In this particular example, the exception was not only the comfort in disclosing personal difficulties to another person but also the willingness to meet with a mental health professional. Of those participants who requested help in the emotional realm, disclosures were made to physicians, ministers, friends, and family; not mental health therapists. This particular individual's opinions reflected his personality and successful historical contact with mental health professionals. His past contact in particular differentiated him from the other participants.

As evidenced previously, participants had different comfort levels in requesting assistance of an emotional and more personal nature. Some husbands recognized a need of this nature but rather than directly requesting help for themselves, diverted attention to their wives and as a result of the attention given their wives, gained a sense of emotional relief.

> I got the phone for her for, that her family could phone to her ... they could be in touch with her. And large family ... and they couldn't go, but they could phone her, you see, to visit her. And I would go once a day, or maybe twice a day but (pause). Well, I, I just say, I have my brother-in-law and they were too cheap to do that, so the poor man, I don't know, he was just a nervous wreck running up there staying at the hospital all the time. So if they'd have had, you know, been encouraged to take the phone so her sisters could have phoned her. My wife's sister, you know, this would have helped him because he prit-in-near perished. So often the caregiver is the one who is really under stress. So, it's just not only the person in the hospital. (T)

Thus, in accessing resources for their personal needs, husbands could on occasion divert attention from themselves, fulfilling personal needs in a more indirect fashion.

Receiving Solicited Help

As a consequence of participants' requests for assistance, the resources usually responded with solicited help. Solicited help of a personal nature was most clearly evident amongst those participants with spiritual beliefs. They had relationships with God and described how important their faith was to them.

> It's far easier and, whether that word 'easier' is the right word or not, I'm not sure, but for us as human beings, if we have faith ... What does matter, that we have a faith and that we believe ... To me, whether it's Muslim, whether it's Buddhism, whether it's Ahurmazdaism, and who am I to say that Ahurmazdaism is, is worse or better than Buddhism or, I mean, so much depends on what it is, where we are and how we're brought up, and what happens. But we need something inwardly to hold on to. A stanchion, a crutch if you want to call it that, to support us. (R)

Some participants had drawn personal strength and comfort through their personal relationships with God over many years.

> I was born out of wedlock in [city]. And so, being a bastard, this sort of (pause) caused depression in my life. But when I became a Christian, I found out that the Lord was the Father of the fatherless. That was comforting to me. (T)

For these husbands, spirituality was not something relegated solely to Sunday practice.

> It's interesting how some people think that the membership in their faith or their church is something that they just bring out and wear on Sundays and the rest of the week they forget all about it. The Bible is something that stands on a shelf and gathers dust and isn't read ... Something as important as, as, as one's spiritual life and whether what's the purpose of your being on this earth and what are you trying to accomplish and I mean it explains and gives answers to so many things we have as frail human beings. (R)

> It's [spiritual faith] for real, it isn't just some kind of a going-to-church thing and church, it's right where you live, where there's home and school or wherever it is. (T)

Some of the participants with spiritual beliefs did not experience any changes in their relationships with God after their wives' health began to deteriorate. They continued to practice their faith as they had earlier in their lives. Others strengthened their beliefs and felt closer to God following their partners' health deterioration.

> There's just my wife and I and we don't have any other brothers or sisters in this country. We are just two black sheep of our family (chuckle) you could say out here. And so, when it comes to a point like that, you know, like when a person is goin under a serious operation and when the - well I asked the doctor just prior to and he had told me that she had cancer of the liver and cancer of the bowel, I asked him what the chances and he said the chances are not very good ... So those things make your, your faith stronger, you know ... I did pray more ... I gone over what we say is the rosary ... I always went to mass on Sundays and all that but I go now daily ... So we both go to - every, every day. So, I think it has made us stronger that way - both of us. (P)

Participants with spiritual beliefs described various ways in which they were able to claim personal victories through their faith in God, who, they believed, answered their prayers.

> If something's bothering you, you tell the Lord, ask Him to take it away. (J)

> I said, you know it's just human, I said Lord, I said, you said I, your promises, you said, I'll never leave thee nor forsake me. I said you've forsaken us. Look at my wife and look at me. I'm a, I'm so tense and, and then just out of the clear blue, a beautiful scripture came to me that - the man who led me to Christ used to quote as he went to visit the sick in the hospital. I think it's Isaiah 41:10. Maybe I should read that because I could quote it but I might not get it exact. ... [T retrieved his Bible] ... so let's see if I have this right, 41:10. "Fear thou not for I am with thee. Be not dismayed for I am thy God. I will strengthen thee. Yeah I will help thee. Yeah I will uphold thee with the right hand of my righteousness." Wasn't that a beautiful thing? (T)

Although the participants illustrated above relied on God for personal assistance through troubled times in their lives, their relationship with God did not preclude relationships with people. These husbands also sought and received assistance from people, although frequently at a less intimate level (e.g., digging up the garden). They generally felt more comfortable unburdening their innermost selves to God than people.

Husbands received other types of solicited assistance as well. Examples included medical information pertaining to their wives' condition, chances of survival, medications, and surgical procedures. Husbands found the information to be helpful in terms of reducing their uncertainty and providing greater peace of mind. Other solicited assistance of benefit to them was in the form of instrumental help. Transportation to appointments enabled them to access services for themselves. As discussed earlier, yard work and other physically-related assistance enabled husbands to preserve their strength and avoid potential injury.

Receiving Unhelpful "Help"

Husbands solicited relatively little personal help from other people. As demonstrated throughout the chapter thus far, most help was sought at the marital level where requests were framed in terms of assistance for tasks related to providing care to their wives. It is suggested that as little assistance was sought at the individual level, there were fewer incidents of unhelpful "help" at this level in comparison to the marital level.

DOVETAILING RESOURCES

The basic social psychological process (BSPP), "dovetailing resources," integrates the input of external resources (solicited and unsolicited) with the husband's personal resources - at both the marital and individual levels. There is continuous movement and interaction at the personal and interpersonal levels with husbands dovetailing their personal resources with external resources in order to maintain their preferences for resolving issues as independently as possible. At the marital level, marital resources are utilized to their potential while at the individual level, personal resources are utilized in preserving the optimum level of self-sufficiency. The first phase of the dovetailing resources BSPP is therefore similar at the marital and individual levels. While participants varied considerably in terms of how strongly they adhered to their preferences for self sufficiency, none considered accessing external resources to be indicative of failure. Accessing external resources was the second phase in dovetailing resources as husbands broadened their resource base to cope with the issues related to their wives' health deterioration.

Upon receipt of external assistance at the marital or individual level, husbands engaged a decision-making process concerning whether they needed to continue accessing external resources. Were the marital and/or personal resources sufficient in themselves to continue? Was additional assistance required? Depending on the answers to these questions, husbands either returned to a more self-sufficient modality, restricting the amount they accessed external resources, or continued to access external resources for further assistance. The decision-making process was also influenced by numerous conditions as described in previous sections. In dovetailing resources therefore, husbands meshed their personal resources with those outside their marriage and personhood (reflecting the marital and individual levels respectively). In doing so, their intent was to care for their wives and themselves by their preferred means - as independently as possible.

An example of this process at the marital level concerns interactions with the wives' formal network. As reviewed earlier, husbands were assertive in seeking information in order to enhance their skills in meeting the health care needs of their wives. Upon successfully implementing their newly acquired skills in providing for the health care needs of their wives, they could choose whether to continue accessing the external resources or return to the mini-BSPP of dovetailing marital resources relatively independently of other external resources.

> All the skin off her heel and off the instep and under her toes and all that skin was comin off. They [home care nurses] came out and they were goina put bandages on one way. Well they did show me how to put it on, but the next night, then I turned around and I done it another way and it, and then when they came out again, well that was the way to do it. (E)

Of all relationships discussed during the interviews, those with their wives' medical care personnel were, with few exceptions, the most distant to husbands. Nevertheless, husbands still exercised responsibility within the medical realm and dovetailed their personal resources with their wives' formal network (as witnessed in the previous illustration). However, as husbands were not the patients and were therefore relatively powerless in the medical system, dovetailing the marital resources with external resources was not always clearly defined.

Participants accompanied their wives as frequently as possible during medical appointments and some accompanied their spouses into examination and/or treatment rooms. Husbands accompanied their wives into the examination room for various reasons including: for the sake of providing physical assistance, to be emotionally supportive to their wives, provide information about their wives, and/or learn more about their wives' status.

> All three [including daughter] of us go ... because she, with the stroke, you know, she did have a lapse of memory. So, we're there to learn the information first hand and another thing, to help her out physically because the doctor don't know how to handle her and you have to be

> careful because of that broken arm ... you don't want to aggravate anything. (B)
>
> I, I always wanted to be there and, and even just hold her hand. (R)
>
> I go in, in order to assist [wife] and, and (pause) telling the doctor what kind of a life she's leading and try to retain things that she might miss that he said. It's, it's more traumatic for her (pause) to talk to them and I assume that she might miss more too, because of that. (A)

In the examination room, husbands interacted with their wives' physician and/or nurse and sometimes advocated on behalf of their partners.

> I said, "Dr. T., why can't you order that bone scan?" "Oh no, it's got to be by your surgeon." "Well," I said, "look, you're the metastatic expert here, why can't you do it?" "Well," he said, "I'm going to do it." (R)

At times, participants were uncertain whether to divulge information and if so, the quantity and content of information. They risked overstepping the comfort levels of their wives and/or physician.

> Usually I do, quite a bit of the talking for her, you know. I think I have been told in the (pause), probably from the doctor, sometimes [we've] gone to visit a doctor that um, specialist or whatever, and I've chimed in because it's been my usual pattern, you know, and he's kindly told me, "No, I'd like to hear it from your wife," you see. "Oh, fine, sure, go ahead." But it usually ends up coming back to me anyway 'cause she gets tongue tied. (M)
>
> Too much do I want to interject and my wife will say right in front of the physician, "Now wait a minute, who's being examined here? Just listen, let me talk first about that." (chuckle) ... And I say, "Oh yeah, sorry about that." I want to jump in and ask questions and make comments ... Giving more of an explanation of her feelings. She's a little less interested in giving the full story, and I'll want to give more details. (R)

It was difficult at times to know how much responsibility to assume in the medical realm, particularly if communication between husband and wife was not clear.

> I answer quite a bit ... sometimes she doesn't agree with what I, she, she tells me you, you were (pause), "you do too much talking," like, you know. I said, well, (pause) "you always tell me you can't think of things," like, you know. Sometimes you can't win, you know. I'm trying to do her a favour and ask questions for her (pause) and she says, "yeah, because

> you were doing all the talking, I was going to ask the doctors so and so," you know. So, I think to myself, what the heck, I can't win ... [if I held back] I'd be told, well, why didn't you remind me, just tell him [doctor] so and so, you knew this and you knew that ... Pretty hard to win. I just, I just take it in my stride, that's it. (M)

Therefore, dovetailing external and marital resources was not always smooth but participants strove to mesh resources as best they could.

One way of resolving the uncertainty was to withdraw somewhat from contact with their wives' formal network. Husband's, in respecting their wives' privacy, provided their partners with greater independence but also removed themselves from the uncertainty surrounding their involvement.

> When I take her to the cancer clinic, the first, well when she was in the wheelchair, I didn't mind. Go in there, go in the office and talk to the doctors and stuff - I didn't mind that. I kind of enjoyed that. But as she got better now, the last time I didn't go in the doctor's office because I know that she's healthy enough to do her own thing. (E)

> I can go in if I want to you know but I don't. I'll leave that to the doctor and his patient. That's the way I look at it you know. That's the way I would like to be treated. Like if I have, with my doctor and myself ... I'd come in if she said "I'd like you to come in." Yes, I definitely would, yeah. But then I'd know she wanted me to come in. But I would think I was invadin their privacy or something like that or something like this, if I, if I walked in on my own or something like that. (P)

Unhelpful "help" also contributed to the dovetailing resources BSPP. As described previously, not all of the solicited assistance was helpful to participants. Examples of negative consequences were provided earlier. However, unhelpful "help" was not restricted to the actual receipt of negative interactions. Perceptions of potential negative consequences of receiving assistance could reduce the likelihood of requesting assistance from a source. At the very least, husbands considered this potential before requesting assistance. For example, a reluctance to request domestic assistance could arise out of concerns that the level of service would be below personal standards. Other concerns could also arise reducing the likelihood of accessing external resources.

> I hate to be as blunt as this but (pause) I know I probably should be above all that, but you know my wife in the hospital and (pause) I, I just didn't have no, I didn't want a woman coming in here because I (pause)

> well (pause) I don't know how to say it, I'd rather do a little vacuuming myself and have it a little dirty, I had no company anyway ... I, I just didn't want to get involved with, with (pause) well, put my face where I was tempted. I'm talking straight talk, but I'm just saying I want to be true to my wife and true to the Saviour, and I don't go and put myself in a place where there's (pause) you know (pause) so, not that I couldn't trust the woman, but I, or myself, but I just meant ... I just don't give it any chance at all, well to put it bluntly. (T)

> You have to be very careful who comes into your house and what happens because we have heard stories about different things, and you have to be careful. If there's dishonest people, and there's stories about this, some of these women that work for home care, like, they go (pause) and demand drinks of patients and (chuckle) the women have to be careful they go to visit some of these old guys and they're looking for sex (chuckle). And like I say, you have things all around the house, you have to know somebody who's trustworthy that you know who's coming. If you don't, you're not afraid to lock up all the rooms ... As far as somebody's coming, yeah, that's a very good idea, but you like to know who the heck it is. (B)

Dovetailing resources at the informal network level incorporated the input of husbands, wives, and others in requesting and receiving assistance. To the greatest degree possible, wives were consulted and encouraged to participate in decision-making regarding their well-being. Wives were also encouraged to express their preferences regarding their personal care and were included in action plans.

> Everybody's [children] equally interested [in parents] but the only thing is, she [wife] would rather have the girl, the daughter look after her than the boys. Like, like she wouldn't want to have one of the boys come and change her pyjamas at night, put her in her pyjamas and put her to bed, unless it had to be done. (B)

> She was really concerned, the fact that we weren't getting replies from this doctor, and I, I said, well, you know, "I'd better phone [a physician known by the husband]" ... I didn't do it without her, together we worked out what we'd do and one thing just let to another thing. (R)

Dovetailing marital and external resources at the marital level, and personal and external resources at the individual level, was a continuous process dictated by the needs of participants and their partners and the responses of others to the requests for assistance. It should be noted that assistance was not always of a tangible nature. The social context has been described previously - husbands and their partnerships are embedded in a network of relationships. Some relationships were long-standing and intimate, others were of a more recent and distant nature. The very existence of such a relationship network provided support to husbands apart from the actual exchanges of assistance. The back-up, or safety net characteristics of these relationships, afforded husbands the opportunity to undertake greater responsibility for their partners and themselves.

> I have an awful good friend ... He is a millionaire and he always told me that during sickness, "if you ever need money," he said, "don't be scared." He says, "you got my number." ... It [offer] had a great relief. Great relief that I knew that if I needed 100 or 1,000 or whatever, it was there for me, like in (pause) because last summer when we went to [visit family] I was talkin to him and he says, "if you need any money," he says, "$1,000 or," he says, "you know my number. Let me know." (E)

> I want her [home care nurse] to come because I want , I want somebody around that I can contact anyway, if I have to ... she's got the office there by the [store] in town there ... I can get hold of her over practically any time, you know. And so that's, yeah, that's a bit of (pause) that's a bit of comfort to me to know that she's there, and to my wife. I've even told my wife, is that you phone any time you want to, you phone [nurse], you know, if you want a little booster, a morale booster. (M)

Every participant identified at least one relationship that provided him with a sense of safety, of security. Relationship sources included offspring, family, friends, and/or neighbors. The availability of their wives' formal network cast a broader safety net for husbands. Family members, predominantly children (if applicable), were mentioned more often than others as the people comprising the safety net. For some participants, safety nets were composed of single relationships whereas for others, safety nets were composed of multiple resources.

In maintaining responsibility for wives and selves, participants identified people who possessed skills viewed as complementary to their own. The identified skills were often medical in nature but could also include supervision of their wives or domestic assistance as further examples. Inclusion of others with valued skills meant husbands would not be relied upon for absolutely everything.

> Don't rely on me for, for everything, like in, you know, medical ... no, I want somebody [home care nurse] to come in that has knowledge of that, and that can, if they think something has to be done, they could get in

> touch with the right authorities, you know, whether it be my doctor they might have, want to tell him something you know. (M)

In differentiating marital and individual levels, there is a risk in assuming that the two processes are independent from each other. However, the findings presented thus far have dispelled such an assumption. The dovetailing resources BSPP is also integrative. Dovetailing resources involves the decision-making process revolving around the amount of energy devoted to the responsibility of caring for wives (marital level) and the responsibility of self-care (individual level). Generally, husbands prioritized the former with this being the most clearly evident during times of crisis. At other times, participants dovetailed resources in order to meet both areas of responsibility, harmonizing the marital and individual levels.

> I look after my wife, and that, that is one reason why I did stay on at work longer. See, a lot of people might have thought, well, you're 65 now, you should retire because your wife has cancer, this and that. Knowing what it would be ... she would be sleeping, I'd be just there, and I, see half the time even when I was at work, she'd quite often she'd lay in bed half of the day. I mean that's not a good thing either, but I think, I think also as the spouse, you do have to think of yourself too. Like I have to think of myself unselfishly. I do. I know, I've got enough sense to know that much, I do. I do know that I have to, I have to take care the best possible way I know how. I have to take care of my wife. She, she deserves it, she needs it, you know? And I still have to look at my side of the story too, eh? (M)

Another example of marital and individual level integration pertains to respite. Respite was a means by which some participants set limitations on their responsibilities to their wives, thereby caring for themselves as well as their wives. In general, participants demonstrated abilities in setting limitations on the responsibilities they undertook for their wives. In being aware of their own individual strengths and weaknesses, they could pursue activities and balance their responsibilities to their wives with self care.

> She [acquaintance] was saying there's lots of work around for you ... there's lots of pensioners here that would love jobs done ... And I thought, well, sure, you know. Do things at a reasonable price, you know, which, I could build basements or whatever they want, you know. That might be the answer, to keep myself busy on things, you know. Stuff that I like doing. Because, I mean ... I don't want to be a full time nurse ... I just, it just doesn't fit in with me to be, to be a nurse. (M)

Through integration of the two levels, it was possible for husbands to retain a relatively high degree of personal self-sufficiency at the individual level while experiencing greater dependency on others at the marital level. In a sense, the assistance received from others at the marital level diluted the assistance required at the personal level as assistance was targeted toward husbands' partners or partnerships as opposed to husbands specifically.

The integration of the individual and marital levels is further evidenced in providing care to one's partner (marital level) as this can result in enhanced self-esteem (individual level).

> I felt (pause) great satisfaction that I didn't have to get any outside help (pause), to look after her more than the RN's when they did come into give us advice if we needed it. (E)

This illustration also reveals the preference for self sufficiency in combination with openness to accessing external resources.

Resources could be dovetailed at the marital and individual levels in light of health considerations of both partners.

> I have a four hour stretch there once a week to go and do my shopping and banking and whatever I have to do ... And Saturday the daughter comes. (B)
>
> On Saturdays (pause) if I need to, I go to the mall or something to do (pause) fill out the other things that I can't do on Thursdays, because Thursdays, pretty well restricted to grocery shopping and banking but then there's other things that are needed, like clothes ... if I have to go get a haircut once a month, that's usually on Saturday. It gives me a break from cooking. (B)

Some participants, while currently managing relatively independently, were cautious about the future as their personal health histories contributed to their heightened awareness of the potential for future health-related declines. A husband's health status consequently took on more significance when his partner's health had already declined to the point where she would be unable to manage the household and care for her husband if he experienced additional functional losses. External resources can therefore be sought in assuming responsibility for wives and self care.

> She [doctor] looked at me, looked at my eyes and stuff. So I come home here and told my wife, "look," I says, "I got to go to the [hospital] for tests." So, I phoned my daughter, said make sure you come here after work 'cause mother is by herself, nobody to make supper for her. (B)

> The only thing that I am concerned with, I notice that getting older, is I'm starting to lose a little power ... If we both stay the way we are, eventually, I will not be able to manage, we'll have to go to an (pause) apartment or a condominium or some place that's looked after so I won't have all these extras. (B)

In summary, the dovetailing resources BSPP encompasses a decision-making process concerning the preference for self-sufficiency, at both the marital and individual levels, and accessing external resources. The BSPP also serves to integrate the levels as husbands search for the best fit, or balance, between the responsibilities they assume for their wives and themselves.

In the following chapter, the dovetailing resources BSPP is reviewed in light of the relevant literature.

CHAPTER V: DISCUSSION OF FINDINGS AND CONCLUSIONS

Once the categories and theory have emerged from the data, the researcher returns to the literature to integrate the emergent theory with the work of others. This stage of the research process is consistent with the preceding data analysis in that it is generational, not verificational. That is, differences in the emergent theory and the work of others "do not produce verified or unverified hypotheses or findings" (Glaser, 1992, p.33). In reviewing the literature, the researcher is not looking to negate or invalidate what others have done but instead, seeks to explain it in view of the researcher's findings. Variations may occur as a result of different conditions and it behooves the researcher to demonstrate this.

In the present study, the BSPP of dovetailing resources entailed a central dynamic involving the preference for self-sufficiency (as a couple and as an individual) and dependency as evolving from the recognition of limitations necessitating the need to request assistance from other people. The participant's strategy of assuming responsibility for caring for the partner and self leads to this process. Several conditions influence the decision to request assistance with the outcomes of the requests then viewed in light of the preference for independence.

There is a paucity of theories incorporating comparable dynamics as they pertain to elderly people. In returning to the literature, I recalled that Erik Erikson included the concept of autonomy in his theory of psychosocial development and as it seemed relevant to the dynamic in dovetailing resources, I researched his theory further. In the process of rediscovering his theory, it quickly became evident that several of his psychosocial stages were consistent with the accounts of the participants in the present study. Throughout this discussion, many references are made to the work of Erikson and his colleagues which pertain to the themes emerging from the present study. Therefore, his theory is briefly reviewed as well as the methodology he and his associates employed in a study addressing psychosocial development in later years. Following this review, similarities and differences between the present study findings and those of Erikson and his associates will be discussed. The applicable psychosocial stages of Erikson will be briefly introduced and compared to the present study. In addition, relevant research by other authors will be cited. The greatest emphasis is placed on the Eriksonian stage of "autonomy versus shame/doubt" as it is of most relevance to the process of dovetailing resources.

Before discussing the self-sufficiency - dependence dynamic, however, another main conclusion from the present study is presented as it provides a backdrop to the consideration of autonomy. Namely, participants seemed remarkably comfortable in assuming responsibilities in arenas that were for most, quite foreign to them. While there were transitional and coping difficulties, participants in general were at ease with the role of assuming greater responsibilities for domestic tasks and providing care to their wives. Their comfort level is explored in terms of the participants' nurturing qualities. This discussion sets the stage for the aforementioned central dynamic of dovetailing resources.

After the findings have been discussed, the study's conclusions are presented followed by the limitations of the study and suggestions for future research. A section on practical implications of the study for health care professionals concludes this chapter.

Discussion of Findings

In this section, the literature is revisited to compare the emergent theory of dovetailing resources to the work of others.

Overview of Erikson's Theory of Psychosocial Development and Berkeley Study

Arguably, the best known theorist addressing developmental issues in adulthood is Erik Erikson. He proposed that psychosocial development occurs over the duration of life, resulting from an interaction between internal desires and external social demands (1959). He identified eight stages through which people pass and revisit throughout their lives. In 1986, Erikson co-authored a book with Joan Erikson and Helen Kivnick relating the eight stages to major problems in "vital involvement" in old age and vice versa - relating vital involvement to the stages.

Each of the eight major stages has two seemingly contrary dispositions (syntonic and dystonic) with vital involvement dependent on the balance between the two. The stages are briefly summarized below with the initial developmental age of undertaking, syntonic and dystonic dispositions, and the adaptive strength arising in conjunction with balancing the contrary dispositions.

1. Infancy: basic trust versus basic mistrust - hope

2. Early childhood: autonomy versus shame/doubt - will
3. Play age: initiative versus guilt - purpose
4. School age: industry versus inferiority - competence
5. Adolescence: identity versus confusion - fidelity
6. Young adulthood: intimacy versus isolation - love
7. Adulthood: generativity versus stagnation - care
8. Old age: integrity versus despair - wisdom

At each developmental stage, the individual experiences "creative tension" between two opposing dispositions. Of particular interest for people of advanced age, individuals not only struggle with "integrity versus despair" - the focal tension for old age - but also in reexperiencing past tensions that were not adequately integrated when they were focal. Furthermore, tensions that were adequately integrated at the appropriate age may resurface as the integration is no longer adequate under present conditions.

> At each successive stage, earlier conflicts must be reresolved in relation to the current level of development. Thus, the principle of reexperiencing suggests that the old-age struggle appropriately to deal with the tension between integrity and despair depends very largely on an individual's age-appropriate balancing of earlier psychosocial tensions, and also on his or her current resynthesis of all the resilience and toughness of the basic strengths already developed. (Erikson et al., 1986, p.40)

It is noted by Erikson that while the themes are considered separately for the sake of clarity, the psychosocial themes in old age do not represent eight independent processes.

> Rather, the themes represent a set of perpetually intertwined concerns, inseparable by virtue of their lifelong interconnections as the essential motifs of the life cycle ... themes are intertwined in such a way that involvement in a particular relationship or activity (for example, identification with the succeeding generations' triumphs) may be related to the elder's reconciling more than one psychosocial tension. (Erikson et al., 1986, p.144)

Moreover, the processes can be "partly conscious and partly unconscious - processes that the individual may have 'a sense of' but to which he or she by no means necessarily gives deliberate direction" (Erikson et al., 1986, p.39).

Rather than explore the resolution of each stage for each appropriate age, the focus in this chapter is to highlight the stages of particular significance for elderly husbands engaged in caring for their wives. Before proceeding, it is helpful to note how Erikson, Erikson, and Kivnick gathered data for their 1986 examination of old age. Over several years, Erikson and his colleagues interviewed 29 octogenarians; people who, along with their children, had been involved in a longitudinal study for over 50 years. The "Guidance Study" of the University of California at Berkeley began in 1928, following the lives of a large group of children born in 1928-1929. Parental information was also collected at regular intervals and for the group of informants in the study by Erikson and his colleagues, data were available dating back to when the current octogenarians were the young to middle-aged parents of adolescents. In the 1940's, Erik Erikson compiled summaries of the first decades of 50 childrens' lives and their family milieus. Included in his writings were abstracts of the parent's personalities and child-rearing styles. For their study cited here, the authors selected surviving parents of these 50 children. A further criterion for selection was the local availability (i.e., within a four-hour drive of Berkeley). Of the informants, 10 were married, 5 were single men, and 14 were single women. The authors integrated the longitudinal data with data from their interviews.

The "Guidance Study," while offering rich longitudinal data, has limitations. The informants were drawn from a single geographical location in the United States. By definition, informants were parents thereby reducing generalizability of the results to childless couples and single men and women. Further, while the subjects were "ordinary" (i.e., selected randomly on the basis of the birth date of their children), the community of Berkeley could not be described similarly. The 248 original participants (every third child born over 18 months in 1927-1928) were accrued in a community where, according to census data, parents had below average incomes but higher than average educational status. They were also more likely to be homeowners and to enjoy the conveniences of labor-saving appliances (Eichorn et al., 1981 cited in Erikson et al., 1986). Furthermore, the continued involvement in a project of such a long-standing duration may have sensitized and influenced informants in ways that separated them from noninformants. In summary, there are limitations (as with all studies) to the study conducted by Erikson and his colleagues but they are offset by the wealth of data collected over a period of many years. The length of their longitudinal research has been rarely paralleled by other studies.

It should be noted that the study by Erikson and his associates sampled informants older than the participants in the present study (eighth to ninth decades versus mid-sixth to early seventh decade respectively) and as a result, developmental issues may not be entirely comparable. A criticism of Erikson's theory is that while his early stages are of relatively short duration spanning a few years, the last two stages in particular can each span over three decades. "Old age" encompasses a very heterogeneous span of life and consequently, many issues discussed by Erikson and his associates are not necessarily of similar relevance to a relatively healthy "young-old" population (i.e., the participants of the present study). Of further interest, the study by Erikson and his colleagues differed from the present study in that they began their study with a comprehensive, life cycle theoretical framework and supplemented it on the basis of the responses of their sample. In the present study, theory was generated within a significantly narrower field of interest. As such, it neither proves nor disproves Erikson's psychosocial developmental theory.

The contrast between Erikson's focus on individual psychological processes and the present study's primary focus on interpersonal processes is most clearly demonstrated in addressing Erikson's final stage. The overarching Eriksonian psychosocial stage in old age is the tension between integrity and despair. However, as alluded to previously, in addition to balancing this tension, Erikson posits that elderly people strive to reconcile the earlier psychosocial themes and to integrate them in relation to their old-age development. At this last stage, elderly people seek to create a unified whole of their unique life cycle, striving to bring prior psychosocial themes into as much balance as possible.

According to Erikson, the two conflicting processes of integrity and despair entail a review of life and coming to terms with the life lived to the present time.

> The elder is challenged to draw on a life cycle that is far more nearly completed than yet to be lived, to consolidate a sense of wisdom with which to live out the future, to place him- or herself in perspective among those generations now living, and to accept his or her place in an infinite historical progression. (Erikson et al., 1986, p.56)

Erikson and his associates describe the majority of their informants as thinking and talking about dying, being depressed, and feeling let down in some ways. Informants also spoke of their concerns for what they perceived to be disturbing societal and worldwide trends (e.g., ecological concerns related to the ability of feeding the world's population). To counterbalance this, they thought of more life-affirming involvement. Many spoke of viewing their grandchildren as extensions of themselves into the indefinite future.

In the present study, participants spoke of few themes described above. Their references to a life review concerned past vocational and social interests but predominantly reflected their preoccupation with their spouses. Participants spoke often of events, times, and places that comprised the mosaic of their marital histories rather than their individual histories.

One exception, consistent with Erikson's eighth psychosocial theme, concerned physical health. Particularly evident in participants who had experienced health difficulties, there was mention of the fact fewer years were to be lived than had been lived. However, even these references were frequently within the context of wondering what impact the demise of the participant's health would have on their wife's well-being.

That participants voiced few themes consistent with Erikson's stage for old-age may be attributable to several factors. First, participants may have little time to consider such personal issues in light of the responsibilities undertaken on behalf of their partners. However, this explanation would not seem to apply equally to all participants because a few, as demonstrated previously, had more limited responsibilities owing to the relative health of their wives. Second, focusing on their wives may enable husbands to postpone, or even deny, the personal work to be done at this stage. Third, husbands may have been uncomfortable voicing such processes even if they had occurred or were presently occurring. Given their wive's health, such ruminations could be viewed as inappropriate. Finally, participants may not yet be fully engaged in this final stage as it was noted previously, the informants in the study by Erikson and his colleagues were in their eighth to tenth decades of life. Perhaps the final developmental stage is more fully realized later in life.

By virtue of the chronological age of the participants in the present study, Erikson's last psychosocial stage is pertinent. However, it is recalled that according to Erikson's theory, the previous stages, already passed through in some fashion earlier in their lives, are revisited in older age in light of current circumstances. Some of the stages are particularly applicable to the circumstances surrounding the experiences of husbands witnessing the deterioration of their wives' health.

The two primary themes emerging from the present study are considered below. The first to be presented concerns the comfort with nurturing that participants manifested in several ways. The second theme pertains to the central dynamic between self-reliance and dependence which comprises the BSPP of dovetailing resources. As indicated previously, with the exception of Erikson, there is little theory to compare the present findings to. However, his theory, and in particular his collaborative effort in 1986, was found to be especially germane to the present study. Consequently, references to his theory are oft recurring with the results of other researchers also included as relevant to the discussion of the findings.

Nurturing: Comfort in Caregiving

As reviewed previously, the health deterioration of the women in the present study and the subsequent amount of care provided by husbands was markedly varied. Moreover, some participants were contributing in the domestic and physical care provision arenas for the first time in their lives whereas others had eased into the transition years earlier. In the midst of this diversity between participants, however, husbands consistently described themselves as comfortable in assuming responsibility in these areas.

Kaye and Applegate (1990) surveyed male caregivers of frail elders and similarly reported that the caregivers were comfortable with assuming caregiving responsibilities (the majority of men were over 60 and were retired; the women's frailties included arthritis, rheumatism, dementia, and visual and auditory deficits). Miller (1987) likewise reported that husbands of cognitively impaired partners mentioned the comfort with which they eased into assuming household responsibilities. An earlier study reported similar observations. Vinick (1984) interviewed a sample of widowers whose wives had died 30-36 months prior to the interview. Most of the widowers of wives who had been disabled prior to their deaths had assumed primary responsibility for routine day-to-day caring. She concluded that most of the widowers "seemed to accept the role of caretaker uncomplainingly as one that it was their duty to perform" (p.64).

Amongst the participants in the present study, there were those who saw their contributions as a "duty" in terms of their marital beliefs and marital history yet this explanation in itself fails to encapsulate the sense of meaning that husbands ascribed to their contributions. Fulfilling marital vows, while influencing the husbands' desire to care for their wives, would not seem to adequately account for the expressed comfort in assuming responsibilities for partners.

The work of David Gutmann (1987) offers an additional explanation for this apparent comfort. He researched adulthood personality characteristics across three different cultures including the Navaho, the Mayan, and the Druze. Gutmann found that with advancing age, men and women tend to assume different characteristics in regard to masculinity and femininity. In comparison to younger men, older men become more nurturant and expressive; characteristics traditionally associated with feminine traits. Support for Gutmann's observations was found by Kaye and Applegate (1990) as their male sample viewed themselves as possessing affective, expressive, and nurturing personality traits. Similarly, Pruchno and Resch (1989), who compared male and female spouses of dementia patients, observed that husbands displayed greater emotional investment in their relationships with impaired spouses than did wives of impaired spouses. Providing care to a spouse can therefore be harmonized with the emergence of personality changes (Pruchno & Resch). The deterioration of their wives' health affords elderly husbands the opportunity to exercise their emerging nurturing behaviors.

The manifestation of the nurturant and expressive characteristics was varied amongst participants in the present study. While growing more confident in their abilities in these regards, participants were not uniformly apt to express their emotions openly or self-disclose freely. Indeed, as reported in the previous chapter, it appeared that participants often withheld from their partners the depth of their concerns for the well-being of their partners in an effort to undergird them with "strength." One example was the reluctance of most to avoid discussing death beyond pragmatic considerations. As participants often identified their wives as their primary confidants, there would appear to be a conflict between the emerging traits of greater affect expression as suggested by Gutmann and others, and the desire to protect their wives by withholding some concerns and affective expressions.

For most participants, the preferred manner of nurturing remained linked to instrumental types of behavior. Participants performed a myriad of domestic and health care functions with few complaints. However, some indicated they had established boundaries around their assumed responsibilities. This dynamic draws attention to the trade-off between nurturing one's partner and oneself which is addressed in a later section.

Erikson's theory is also of relevance to the consideration of nurturing behavior in late life. In particular, two psychosocial stages - generativity versus stagnation and intimacy versus isolation - address issues that were described by participants in the present study.

Generativity and stagnation: Care. Erikson's theory of psychosocial adult development alludes to nurturing behaviors in older age. The psychosocial stage of generativity versus stagnation, ascending initially in adulthood, refers primarily to the experiences of caring, nurturing, and maintaining. The implications of this stage in later life are described by Erikson and his associates (1986):

> Today's elder must balance the feelings of generativity and stagnation developed in the course of middle age's active parenting, working, and creating, all completed decades before. In addition, the elder must come to terms with the caring and the lack of caring experienced as a child, at the hands of his or her own parents, and as an adult, having been responsible for these same parents in their old age. (p.73)

For the purposes of our considerations here, the first quoted sentence above is of most relevance. Participants did not discuss issues pertaining to their childhoods and/or their relationships with their parents. Other facets of this stage described by Erikson and his associates are of limited relevance to the present study as well. In their account, considerable attention was given to the manner in which informants proudly recalled their children's accomplishments and the role the informants played in providing the wherewithal for their children to succeed. In the present study, participants spoke occasionally of their roles as parents in the past and present but often described their wives as making the most contributions toward their offspring's nurturance. Similarly, the role of grandparenthood is also portrayed as an opportunity for demonstrating care in old age by Erikson and his colleagues. In the present study, while some participants spoke of their involvement with grandchildren, more often than not it seemed limited in scope and time involvement, perhaps again reflecting their preoccupation with their wives.

An additional issue discussed by Erikson and his colleagues (1986) deemed less applicable in the present study was the depiction of concern for the future of the younger generation and the survival of the world. Again, this disparity between the present study's findings and a psychosocial stage theme may reflect the increased focus on wives (i.e., the present generation as opposed to future generations). Participants may have had concerns related to the aforementioned issues but they were overridden by their current circumstances in relation to their wives. Furthermore, perhaps concern for future generations and the concern for children, found by Erikson and his colleagues to dominate both past and present involvement in caring, may be more closely related to the experiences of women. This speculation however cannot be adequately examined in the present study because women were not included in the sample.

While there are dissimilarities between Erikson's theory concerning the seventh stage and the present study findings, there are many similarities as well. The authors point out that in the middle-aged adult years, generative responsibility is viewed in terms of the interconnected realms of people, products, and ideals. Old age confronts the elderly person with reduced opportunities to exercise generativity with the family (children), community, and profession or institution. Erikson and his colleagues noted that for one male informant, caring and nurturing primarily entailed making a living for his family. With retirement, this means is usually unavailable. Nevertheless, old age also offers an opportunity to integrate inevitable stagnation in these areas with involvement in generative caring. The three authors describe a "grand-generativity" achievable in older age within current relationships with people. "In these relationships, the individual seeks to integrate outward-looking care for others with inward-looking concern for self" (Erikson et al., 1986, p.74). The applicability of this psychosocial stage to the present study is apparent as participants described their involvement in caring for their wives. Furthermore, husbands sought to integrate the marital level (i.e., "outward-looking care") and individual level (i.e., "inward-looking care"). In non-crisis situations especially, participants pursued self-care while caring for their wives.

Integrating generativity in old age is facilitated by caring for someone else. In the study by Erikson and his colleagues (1986), some informants indicated they were caring for disabled relatives (none were spouses), at home or in institutions. The experiences of the participants in the present study would seem to mesh well in this regard as the men provided care to their wives. Therefore, the participants' comfort in assuming a more nurturant role is consistent with resolving issues pertaining to generativity as theorized by Erikson.

According to Erikson and his colleagues, one of the major realms where elders reface the tension between generativity and stagnation is in their relationships with children. There is a struggle in balancing ongoing feelings of responsibility for the well-being of their children with the recognition that the "children" are adults with needs for independence. In the present study, some participants spoke of their concerns for their children but made it clear that they tended to become actively involved in their affairs (e.g., giving advice) only when invited to do so. There seemed to be less inner conflict regarding generativity with children than suggested by Erikson and his associates. Participants would assist if requested and considered themselves as fully respectful of the independence of their offspring. They saw their children as capable, independent persons well beyond the spheres of earlier parental influence. The loose fit in this regard with the results of Erikson and his colleagues may reflect the prioritization of the marriages. Participants saw themselves foremost as husbands rather than fathers.

It is recalled that an outcome of prioritizing marital relationships was decreased reciprocity with others. Participants described how they had reciprocated assistance in the past with their nuclear family and some still managed to exchange assistance but it was noted that reciprocal exchanges occurred less frequently. In most cases, participants received more assistance from people they were in relationships with (excluding their spouses) than they provided. This was particularly evident in relationships with children. It is suggested by Erikson and his associates that if the provision of assistance by adult children is graciously accepted by recipients, the children's sense of caring responsibility (generativity) is enhanced which, in turn, strengthens the elder's sense of grand-generativity. Participants in the present study provided no indication of grand-generativity in this manner. However, it follows that if by acknowledging assistance, parents can enhance the experience of generativity in their children, the acknowledgments of wives in the present study could enhance a more fulfilled sense of generativity in husbands. Participants indeed reported appreciation for the favourable feedback of their wives in this regard.

The assistance provided by others to participants could be classified in a manner consistent with the social support literature (e.g., instrumental, cognitive, emotional, socializing). One form of instrumental assistance - financial - was commonly noted by informants in the study by Erikson and his colleagues. Financial assistance was both received from and provided to family members in their observations but this was rarely mentioned by participants in the present study. This difference may be related to different national policies regarding federally funded income plans and health cost coverage. Aside from income and expense differences in the United States and Canada, the fact that in the present study only men were interviewed may also have a bearing. Women tend to have much lower retirement incomes owing to the lack of employment outside the home in earlier years. Furthermore, the participants in the present study, being younger and having left their fields of employment more recently, may be more financially secure and therefore, less needy of financial assistance.

Beside financial assistance, other forms of help were exchanged by informants and their middle-aged children in the study by Erikson and his colleagues. "Most elders speak with proud satisfaction of the children's general helpfulness" (1986, p.91). This statement is consistent with the findings in the present study as participants viewed the different forms of help as indications of the love that their offspring had for them. In the present study, this phenomenon was extended to the indirect support perceived by husbands when their wives were targeted for care in some manner.

In concluding this stage, Erikson and his associates noted that their informants focused on past breaches of generativity, wishing they had not occurred. Similar to the recollections shared by their informants, several participants in the present study recalled how they had overlooked the needs of others in the past.

> Maybe they [friends] don't wanna get in, get involved too much? Now I s'pose lookin back at ourselves, I imagine maybe, maybe that's what it is like ... When we were active, I don't know if we knew anybody that was sick (chuckle) ... I suppose maybe it's, you know what goes around comes around. It's a great possibility that, yeah, as I say, when we're active or we seen somebody that was sick we didn't, we'd tolerate it but didn't communicate ... If they came, if they came to our place I guess we'd tolerate them but we didn't go to their place to communicate. Now it's a great possibility see. So, these people here, you look back at it, it could be the same thing. They'll tolerate to a certain extent but they don't communicate. (E)

In experiencing regret for perceived failures in this area, this participant attributes the current withdrawal of some people from himself and his wife in a similar light to his own failures to extend caring to others. Therefore, he harbors no bitterness for their actions. However, he is seizing the opportunity to make amends for his perceived past shortcomings as he has the opportunity to demonstrate caring in the present. He described the efforts he undertook to not only care for his wife but also to reach out to others in the clinic waiting room. Furthermore, he began volunteering to drive other patients to appointments following the recuperation of his wife. This experience is consistent with the overall flavor of Erikson's theory. "It is precisely this process of reconciling the past today in order to live better tomorrow that remains the essence of living with the tensions and challenges of a lifetime" (Erikson et al., 1986, p.104).

Intimacy and isolation: Love. The priority placed on marital relationships by participants following the health deterioration of their partners was not surprising given the number of years their lives had been intertwined with their wives. Moreover, for men in particular, intimacy is achieved primarily through marriage. Strain and Chappell (1982) reported that whereas elderly married men most often named their wife as confidant, elderly married women named their husband and in addition, a child or a friend. If the experience of intimacy for elderly husbands is most likely to occur in marriages, their comfort in providing care to their wives may be related to the meaning attached by elderly husbands to their marriages. Providing care is an avenue whereby intimacy can be practiced and in the process, the sense of love is further strengthened. In this context, Erikson's stage of intimacy versus isolation is of relevance to the findings of the present study.

The stage of intimacy and isolation is first addressed in young adulthood but "throughout the life cycle, a balance between the capacity for intimacy and the need for some isolation enables the individual to engage with others whom he or she can love and be loved by, with true mutuality" (Erikson et al., 1986, p.104). In older age, however, mutuality may not be as obtainable because isolation is imposed by geographical mobility or the deaths of loved ones for example. In order to maintain the capacity for love in these isolating circumstances, new relationships may be formed and joined with existing relationships to reestablish mutuality. For most married elderly people however, intimacy is achieved through long-standing marriages.

In the present study, the participants' marital histories were categorized both as a context within which caregiving occurred and as a resource from which to draw upon for strength and guidance in relation to current circumstances. The previously established intimacy influenced the participants in terms of their resolve to care for their wives. They were determined to care for their wives in their own homes for as long as possible. Similar levels of determination have been observed elsewhere. Motenko (1988) interviewed a small sample of six elderly caregivers of frail wives (none with cancer). Five of the wives were housebound due to their illnesses and all of the caregivers were aware of the option to institutionalize their spouses but resolutely chose not to. Motenko reported his participants' caregiving relationships were "rooted in the relationship they had together in the past. In this way, the past is part of the present and infuses meaning into caregiving" (p.111). Consistent with the present study, providing care can blossom into more than the simple culmination of varied tasks. It can give the old-age relationship renewed meaning and a sense of intimacy. Assuming increased responsibility for the care of their wives perpetuated the meaningfulness in their relationships.

Kaye and Applegate (1990) reported that their sample of male caregivers of frail elders were motivated by feelings of love for their partners. Motenko (1988) similarly stated that the "guiding principles of love and commitment form the basis of the husband's decision to pursue a lifestyle of caregiving" (p.111). However, motivations or guiding principles are difficult to separate as cause and effect. Is love necessarily a causal force leading to caring for one's spouse or can it also be a consequence experienced through exercising nurturant characteristics? Fitting, Rabins, Lucas, and Eastham (1986) found that 25% of husbands of partners with dementia reported that having to nurse their wives intensified their commitment to the marriage and generated increased feelings of closeness and love with their partners. Therefore, the relationship between the provision of care and love may be better defined as circular rather than linear.

One phenomenon that was noted in the present study and has been observed by other researchers concerns the repeatedly voiced beliefs that the participant's marriages were growing closer, or at least remaining as strong as ever. (One participant was an exception to this trend due to his wife's demanding nature, chronic pain, and advanced dependency.) In the study by Fitting and colleagues (1986) cited above, a minority of husbands of dementia patients felt their relationships were growing closer. As discussed previously, the difference between cognitive functional declines and primarily physiological declines usually evidenced in cancer may account for only a minority of husbands expressing this view. In a study concerning marital adjustment following breast cancer, Lichtman, Taylor, and Wood (1987) interviewed breast cancer patients and their significant others (74% were husbands, ages were not provided but patients ranged in age from 29-78). The authors reported that in regard to marital adjustment, both husbands and wives typically described their level of marital satisfaction to have improved or remained the same after breast cancer. There was a reevaluation of the marriages as both partners focused on the importance of their relationship.

Erikson and his colleagues (1986) noted that in their interviews, informants similarly often spoke of their marriages in relatively glowing terms - despite documented evidence accumulated decades previously indicating precisely the opposite. Even when historical evidence revealed consistent distancing between partners, many of their informants were reluctant to allude to any marital difficulties, past or present. Rather, they described gratifying marriages. The consistency of the informants' accounts of marital intimacy was striking to the three authors and they suggested that such discrepancies were indicative of an important psychological process:

> For some elders, after decades in which the balance between intimacy and isolation was often precarious, integrating a sense of love across the whole life cycle may involve the reevaluating and recasting of earlier experiences to such an extent that these experiences become unrecognizable to the outsider. (Erikson et al., 1986, pp.110-111)

Obviously, few researchers have access to marital data like these authors had in order to compare previous marital accounts with current marital descriptions. Nevertheless, their observations are of relevance here for several reasons. First, the degree to which husbands and their wives actually experienced strong and vibrant marriages becomes somewhat moot as in older age, men and women may be in the process of re-evaluating their intimacy and conclude it was actually better than they believed while they were "living the memories." Secondly, in dovetailing marital resources, the perception of a successful marital history was identified as a resource. This resource would be enhanced by focusing on marital successes (rather than failures) as positive past strategies are selectively recalled and used as markers to guide interactions in current circumstances. Third, if marital intimacy is viewed favourably, it would seem more likely that husbands will provide care to their wives than if negative experiences were the focus. If the latter occurred, it would seem that such recollections could only offer additional hardships and indeed, could block husbands from providing care.

Dovetailing Resources: A Dynamic Between Self-Sufficiency and Dependency

Earlier in this chapter, I identified the central dynamic of dovetailing resources as processing requests for assistance in view of preferences for self-sufficiency. My recollections of Erikson's concept of autonomy led me to his theory and the discovery of additional similarities between his theory and the present study. Before addressing the central dynamic in the present study, several psychosocial stages are discussed as they are relevant to the participant's strategy of assuming responsibility, particularly at the marital level. Assuming responsibility is closely linked to industriousness.

Industry and inferiority: Competence. The psychosocial stage of industry versus inferiority has its ascendancy in school-aged children learning to master skills while in the process, developing competence. This continues throughout life as a strength of competence is built through integrating a lifetime of abilities and inabilities. It is the development of a sense of effectiveness that is important here. "Particularly in the face of the physiological and sensory deterioration that, in old age, diminishes longtime skills dependent on physical strength, sensory acuity, and fine motor coordination, a lifelong sense of effectiveness is a critical resource" (Erikson et al., 1986, p.147). Drawing from this sense of effectiveness, an elderly person can persevere in activities that through the years may have become increasingly difficult to accomplish. Remembrances of past industriousness at work or elsewhere can enable some elderly people to experience capabilities even in the face of diminished abilities. Erikson and his colleagues noted that with retirement, a sense of inferiority may ensue because the retired individual has been separated from activities which in earlier times promoted a sense of competence. However, retirement also presents opportunities of a different nature to continue to develop industriousness.

The application of this stage to the present study is twofold. First, as described earlier, a personal history of competence is a resource from which a husband can draw. All of the participants viewed themselves as competent individuals who throughout their lives had accomplished much, primarily in the arena of work-related activity. They generalized these past capabilities to the current home environment where most had had little pertinent experience. Their sense of competence enabled them to approach the present circumstances surrounding their wives, prepared to assume responsibility in this new arena. Secondly, retirement afforded husbands with additional time, an opportunity to continue their industriousness in the form of caring for their wives and to a lesser extent, themselves. In regard to the latter, husbands remained active in hobbies or other interests developed through the years.

The developed sense of competence can be viewed as a resource from which the strategy of assuming responsibility was derived. While the history of past accomplishments achieved via work was a source of confidence, participants were quick to point out their belief that as a partnership, their wives had contributed much and together, they had created an environment conducive to teamwork. Thus, in dovetailing marital resources, participants recognized the sense of competence derived from marital teamwork as well as their perceived industriousness in both their wives and themselves. Husbands did not perceive themselves as individually capable of meeting all of the demands of their situations but within the marriage, these three resources could be dovetailed to meet many of the partnership needs.

The potential of succumbing to inferiority in the face of assuming responsibilities in previously unchartered areas cannot be overlooked. Being confronted with novel and unwelcome tasks associated with the losses in one's life-long partner can be stressful. Erikson and his associates (1986) note that particularly for men, the prospect of providing nurturant and domestic services can be daunting as most have not experienced these challenges previously. However, as documented previously, this fear may be conquered by the sense of competence derived earlier in life and furthermore, suggested personality changes in men (Gutmann, 1987) are consistent with the nurturing requirements of caregiving. Instead of inferiority therefore, a sense of competence may be derived from meeting the new challenges.

In witnessing the deterioration of their wives' health, husbands are faced with a situation that they cannot master completely - they are unable to avert the deterioration in their wives' health. Participants acknowledged the helplessness they felt while recognizing their limitations in this regard. In acknowledging their shortcomings in this or any other avenue, the husbands were matter-of-fact, conveying a sense of acceptance while maintaining pride in what they could still contribute. They emphasized what they were able to accomplish rather than bemoaning what they could no longer do. Motenko (1988) found a similar attitude in his study although caregivers were caring for wives who were homebound and therefore, were apparently functionally less capable than most wives in the present study. Despite these circumstances, Motenko concluded that the "overall experience of caregiving is not associated with stress by the husbands. It is associated with pride and responsibility - not resentment or burden" (pp.112-113). The strains experienced by his sample were seemingly compensated by perceived benefits to caregiving.

Johnson and Catalano (1983) interviewed caregivers (including adult children and spouses, male and female) of discharged elderly hospital patients. At eight months post-discharge, relationships were observed to become redefined through different adaptive mechanisms. One such adaptive mechanism was identified as "role entrenchment" defined as a "process in which caregiving is accepted as a permanent, full-time role that takes precedence over other social roles" (p.617). Reminiscent of Erikson's depiction of deriving competence through industriousness, the authors continue by stating that in role entrenchment, caregivers anticipate "altruistic rewards which enhance his or her self-esteem and sense of competence. Moreover, the role is viewed as replacing major role losses already experienced, so it is seen as giving new meaning to life" (p.617). They continue to depict this adaptive mechanism as becoming so entrenched for some caregivers that other interests and activities eventually become excluded. In the present study, participants were not observed to be so exclusionary. They could, at times, become so focused on their wives that self-care became negligibly evident but this seemed to be a temporary occurrence. Participants balanced a sense of competence with fulfilling caregiving responsibilities and engaging in enjoyable activities in which they could excel.

It is recalled that several participants in the present study had little to provide in the care of their wives because their partners were minimally affected by the health deterioration. While these participants nevertheless assumed responsibility and a protective, guardian role, their sense of industriousness was primarily developed through maintaining their homes. Performing physical tasks in and around the home provided these participants (as with the others) with a sense of competence to compliment their life-history of accomplishment.

Husbands also noted how some of their present competence levels failed to measure up to their standards of earlier life. For example, one participant noticed how his heart problems prevented him from accomplishing what he could have done in earlier years. Another, because of health problems, was unable to complete yardwork without experiencing considerable pain. While disappointed in their reduced capacities, these participants conveyed a sense of acceptance rather than bitterness. They had come to terms with their losses and adjusted their lifestyles and their expectations of themselves accordingly.

The participants, in brief, were able to maintain a sense of mastery into their current ages. Although their health and abilities greatly varied, all took pride in what they were able to accomplish in the present as well as what they had done in the past. A few of the informants in the study conducted by Erikson and his colleagues apparently suffered from greater physical and cognitive deficits than the participants in the present study. Some were unable to find ways in which to meet their challenges and subsequently, became overwhelmed by feelings of inferiority. The participants in the present study were not in similar positions but it would be of interest to follow-up the participants over time to determine if more feelings of inferiority present in view of deterioration in the health of the husband - or wife.

Identity and identity confusion: Fidelity. The psychosocial stage of identity and identity confusion is also relevant to the assumption of responsibility. This stage dominates adolescence but in old age, "the elder faces the task of bringing identity and a sense of identity diffusion into balance by seeking to make sense of the self that has lived through many decades, that lives in the present, and that will continue to live in the indeterminate future" (Erikson et al., 1986, p.129). It bears repeating that in old age, elderly people find themselves experiencing confinements (e.g., health loss) as well as newly acquired freedoms (e.g., through retirement). Individuals who derived their identity principally from specified activities may now encounter restrictions - precipitating the need to reconcile their sense of who they have been "with a newer, everchanging sense of who they may yet come to be in old age" (Erikson et al., p.131).

In the present study, husbands seemed to experience little difficulty in adjusting to their circumstances, including their wives' health deterioration and retirement for example. However, it was also very evident that they incorporated as many life-long pursuits into their lifestyles as possible. Changes were made for various reasons such as health and time availability but changes were not wholesale. There was a desire to continue the identities as defined earlier in life but accommodations were made to alter activities to reflect the present realities of their situations. Erikson and his colleagues (1986) noted that elderly people strive to continue lifelong pursuits as they highlight a sense of self, of who they are. In the present study, this continuity seemed to be a comfort and stabilizing factor to husbands, particularly for husbands of wives whose health had deteriorated considerably.

One of the ways in which continuity was maintained by participants was in the identification of self as a resource, as someone competent to manage both their wives' care and their own. Although the "job" description changed with retirement and their wives' health deterioration, the characteristics on which husbands drew from their employment experiences were intact. Characteristics such as dependability, common sense, knowledge about accessing help, etc. did not vanish with the loss of employment. They were simply redirected toward the needs of their wives. Most importantly, the cherished identity role of "husband" still remained and although there were different demands placed on them, they still fulfilled the husband role first and foremost. Miller (1987) suggested a similar conclusion in her study of elderly spouses of partners with dementia. She focused on control issues and reported that for males, "being in charge of another person was an extension of the role as authority figure in the home and at work. Although nurturing activities may be new experiences for men, taking charge of a situation is not" (p.452). The similarities in the position of assuming responsibility in the home and former work environment may also account for some of the comfort described by participants in the present study and husbands in other studies concerning caregiving roles.

Therefore, in sum, an elderly person refaces issues of identity and identity confusion by "seeking to integrate current caring, love, faithfulness, competence, purposefulness, willfulness, and hopefulness in contemporary society with earlier-life values, beliefs, and commitments" (Erikson et al., 1986, p.147). In the present study, participants gained much of their sense of identity through integrating their life-long beliefs and commitments to their wives with assuming responsibility for them. Concurrently, they were able to define themselves apart from their wives and pursue many activities of life-long interest and fulfillment or adopt new ones in the continual redefinition of their identities. In this regard, there is considerable overlap with the next psychosocial stage concerning initiative.

Initiative and guilt: Purpose. The psychosocial stage of initiative versus guilt first ascends in the play age but is reactivated throughout life as the individual "must continue to temper self-interest and expansiveness with cooperation and concern for others, to exercise disciplined self-limitation" (Erikson et al., 1986, p.169). In order to renew the strength of purposefulness that first arose in childhood, the older adult strives to express initiative through activity. In the process, he or she learns to adapt to limitations posed by circumstances such as personal health. Without adapting, the elderly person is susceptible to giving in to stagnation. "The elder makes use of current involvement, both to reconcile old-age feelings of initiative and guilt and to integrate a sense of purposefulness that will extend backward and forward, across the whole life cycle" (Erikson et al., 1986, p.170).

Several husbands in the present study commented on their diminished capacity to participate in the world. Their range of participation was more restricted than formerly (e.g., parenting, working) but compensations were also made. Alternative activities were discovered to replace former, less accessible ones. The husband's reconciliation of activity with inactivation still involved participation in the world - they had not withdrawn from it to preoccupy themselves with their personal shortcomings. Again, perhaps a less healthy group of elderly people than those participating in the present study would be more prone to engage in the latter.

In reconciling initiative with guilt in older age, elderly people may pursue long established avocational interests in making and creating things. This was demonstrated by the participants in various forms: gardening, woodworking, refinishing vehicles, construction projects, compiling and arranging long neglected photographs of war service, etc. Satisfaction was continually derived from such activities. Several husbands who had worked with their hands throughout their lives were able to transfer or maintain their involvement in similar activities. Such activities were described in the "self-care" strategy in the present study as the pleasure and sense of purpose that their participation afforded them.

Miller (1987) compared husbands and wives of cognitively impaired spouses but her observations of men are consistent with the present study in regard to self-care. She observed that wives devoted greater effort in maintaining social activities with their partners. "Men, on the other hand, were more successful in locating activities for themselves as individuals because their weekly planning perspective often included regular participation in activities outside the home" (p.450). Aside from her finding that husbands are more likely to engage in activities by themselves, Miller's study is also supportive of the present study's differentiation between individual and marital levels for husbands.

Autonomy and shame/doubt: Will. The psychosocial stage most pertinent to the basic social psychological process (BSPP) of dovetailing resources is now addressed. "Dovetailing resources" is presented as a process engaged by the participants to address issues pertaining to self-sufficiency and dependency. There is considerable overlap between this BSPP and Erikson's accounting of autonomy issues. This BSPP illuminates the manner in which husbands grappled with the issue of autonomy in their lives. In the present study, self-sufficiency was extended beyond the individual level to the marital level.

Again, the words of Erikson and his colleagues succinctly state the essence of this psychosocial stage:

> The tension between autonomy and shame/doubt involves very early issues of control over one's own body, one's own behavior, and, in a larger sense, one's own life ... As the body changes and develops throughout the life cycle, capacities for autonomous behavior also develop and change, expanding and contracting with the overall waxing and waning of physical prowess. Along with actual behavioral capacities, individual feelings of self-determination and of helplessness remain connected with the body, and they resurface throughout life - at times, for example, of bodily damage from illness or injury, of the bodily changes of puberty, and of the deteriorations of old age. (1986, p.188-189)

The authors emphasize that concomitant with even the healthiest of aging, some physical (and perhaps mental as well) declines are inevitable. These physiological limitations merge with societal stereotypes regarding appropriate behavior for elderly people. "In the face of new limitations, the elder must struggle to maintain the willfulness and the independence that remain possible" (Erikson et al., 1986, p.189). The three authors noted that nearly all of their informants suffered from some form of physiological and/or psychological disorder but nevertheless, strove to remain independent in the face of their need for assistance. The parallel between these results and the findings from the present study are apparent. In the face of their own health deterioration, participants sought to retain the highest level of self-sufficiency possible. In this process, they, like the informants in the study by Erikson and his associates, endeavored to maintain their "sense of self-determination that is essential to the sense of autonomy throughout the life cycle" (Erikson et al., 1986, p.189). Unlike the informants in the study by Erikson and his colleagues however, the precipitator of the BSPP in the present study was more closely associated with the partner's health loss.

It is important to note that in the present study, participants differed from one another in the degree to which they struggled with autonomy related issues, primarily because of the varied health status. Some participants described their level of independence, at both the partnership and individual levels, to be comparable to the years prior to the cancer diagnosis. Husbands of wives with greater functional ability deficits were more dramatically involved in the degree to which they could maintain their optimum levels of marital and individual self-sufficiency.

The health status of husbands and their partners were identified as two conditions affecting the decision to access external resources in the present study. This is consistent with other research. Stoller and Cutler (1992) reported that elderly people with greater functional impairment (in activities of daily living such as eating, and in instrumental activities of daily living such as doing housework) were more likely than less impaired elderly people to receive assistance outside the household. Erikson and his colleagues found the functional losses in their sample necessitated continuous dependence on corrective procedures and/or aids to daily living. Similarly, in the present study, participants acknowledged their dependence on medication, hearing aids, glasses, etc. In most instances however, participants viewed such dependencies as within the realm of their control. That is, aids were utilized to enable them to function as independently as possible.

Other personal health concerns interfered to a greater extent with everyday activities, affecting the participants' abilities to conduct their daily affairs. For example, yardwork was curtailed because of a heart condition or daily dialysis interfered with socializing and travelling. However, within the parameters of the health-imposed limits, husbands continued to engage in familiar activities. When limitations imposed by their personal health or their wives' health intervened, they learned and practiced new self-directed involvement in substitute activities. The key was that their choices were still primarily determined under their own volition. Erikson and his associates attributed their informants' similar abilities to their reliance on a sense of willfulness developed through the life cycle and continuously renewed in old age. In the present study, this concept was subsumed under the theme of identifying oneself as a resource.

Miller (1987) noted the strong propensity of husbands in her sample of caregiving spouses of cognitively impaired partners to perform domestic duties alone, only occasionally receiving assistance from others. "They stressed their ability to manage their day to day routines by themselves, despite their concern about the fatigue this caused" (p.450). Stoller and Cutler (1992) reported that most of the elderly people in their sample experiencing problems in activities of daily living managed on their own. When requiring assistance, spouses most often provided it and of these couples, fewer than 10% incorporated assistance from outside their homes. In another study, Barusch (1988) conducted interviews with 89 spouse caregivers (mean age of 68.9 years, 35% husbands) of partners with varied illnesses (53% with dementia, none with cancer). She examined problem situations associated with providing care to spouses and identified the effectiveness of coping techniques. Unfortunately, she did not report gender differences but her results seem consistent with the present study. Caregivers in her sample preferred to change situations through their own efforts as this approach was judged the most effective in coping with the problem areas. However, seeking help from others was also judged most effective in many situations.

Participants in the present study also willingly acknowledged the limits of their self-determination as individuals and marital partners. Personal health was the primary intervening factor reducing autonomy at the former level whereas in the latter, both the wives' health deterioration and subsequent involvement with the health care system were largely outside the realm of the participants' control. In reference to the health care system, participants were nevertheless still able to influence and control some aspects of their involvements. They established boundaries on what they were and were not willing to do in terms of their involvement. In setting limits, they were exercising a degree of autonomy and asserting some independence.

In the wake of increased dependency on health care services (e.g., home care domestic assistance), feelings of shameful inadequacy could descend according to Erikson and colleagues (1986). However, even the participants most dependent upon such services from others avoided this sense. For example, some maintained self-determination in requesting assistance at a certain time or of a specified nature. In dovetailing resources - moving between the preferred self-sufficiency mode and requesting assistance from others - participants reminded themselves that no one person could ever be expected to provide for all of the needs they and/or their partners had. In setting such "realistic" standards for themselves, they were able to meet expectations and to be satisfied with their efforts. Husbands also displayed an aptitude for recognizing that their preference for self-sufficiency did not necessarily imply that they needed to physically perform all of the tasks themselves. In assuming responsibility, they at times delegated to others and in so doing, retained as much independence as possible under the circumstances.

Maintaining independence at the marital level was clearly exemplified in the determination of couples to continue residing in their own homes for as long as possible. In dovetailing marital resources, the participants and their wives endeavored to do everything within their power to maintain marital self-sufficiency. Even with failing health, both partners contributed as team members toward their common goal of remaining in their homes. Indeed, the familiarity of their homes, maintained through the years, likely enabled them to manage beyond what they could accomplish in unfamiliar environments. The familiarity facilitates independence whereby compensations can be fashioned for personal losses (e.g., losing one's vision) thereby maximizing whatever degree of autonomy exists. While a few participants were reluctant to accept domestic assistance from external resources (one, for example, because of the disruptions in his daily routine), they voiced greater acceptance of such assistance in light of their overriding goal of remaining in their home. That is, husbands were more willing to accommodate their preference for marital self-sufficiency when external resources assisted them to retain as much independence as they currently enjoyed. The alternative, for some, was institutionalization with the connotation of significantly greater erosions in self-sufficiency at the marital and individual levels. Therefore, in dovetailing resources, decisions were sometimes made on the basis of sacrificing a degree of independence in order to maintain their current level of self-sufficiency, or even improve upon it in light of more dependency-inducing alternatives.

In the present study, other impositions on autonomy were introduced through the unsolicited contact and assistance from other people. Family and friends offered and provided help (and in some case unhelpful "help") of their own initiatives. In most cases, participants were grateful for the attention focused on their partnership and their wives. Interestingly, it is suggested that in being indirectly supported through the provision of assistance to their partners, husbands may maintain a stronger sense of autonomy at the individual level.

They acknowledged receiving emotional support in particular through the acts of others directed toward their wives. In receiving support indirectly, they did not have to "sacrifice" their sense of self-sufficiency by requesting it specifically. Similarly, they more willingly requested assistance for their partnerships and therefore avoided singling themselves out as requiring specific assistance individually. It would seem easier to say "we" need help than to say "I" need help.

It should be emphasized that none of the participants, regardless of their level of self-sufficiency, ever implied that they had been or desired to be completely independent. While they may have been more autonomous during their earlier years, they acknowledged they had always required assistance from others from time to time. Therefore, it is the relative degree of self-sufficiency they wish to maintain that is the essence of dovetailing resources - not the sense that it is an "either-or" dynamic. Clark (1989b), in discussing empowerment, touched on the needs that all people have "for a blend of autonomy and dependence" (p.282). He cautioned that the emphasis on the former by health care policies, while helpful in some respects, may delimit the importance of the need for interdependence in elderly people. It is the balancing of autonomy with dependence on others that is the key. In the present study, "dovetailing resources" provides a glimpse of how elderly husbands attempt to balance these tensions.

Erikson and his colleagues also addressed this interconnectedness of life:

> A corollary of the often-quoted assertion "No man is an island" is the observation that we all need various forms of advice and assistance, as each of us makes his or her own way through life. In old age, as distinct from earlier life, our informants find themselves requiring assistance with a plethora of tasks they had hitherto performed without a second thought. (1986, p.202)

Further, for two of their informants who viewed the receipt of necessary assistance as supplementary to their own contributions, their "balancing of realistic helplessness and embarrassment with longstanding willfulness and assertiveness has involved coming to regard assistance as facilitating overall autonomy rather than threatening or substituting for personal independence" (pp. 202-203). In a similar manner, as reviewed in the previous example concerning self-sufficiency in the home, participants in the present study did not necessarily view the receipt of assistance as contradictory to maintaining self-sufficiency.

The tension around autonomy is evidenced further in regard to the self-sufficiency - dependence balance between partners in their marriages. As reported in Chapter IV, husbands were sensitive to the development of their wives' undue dependence on them and actively sought to discourage this. One means was to encourage their wives to do as much as possible for themselves independently. Recognizing the contributions of their wives in the process of dovetailing marital resources helped decrease the likelihood of wives growing too dependent on their husbands. An additional means was to reinforce the level of their wives' independence while supplementing the husbands' efforts with those of other people. Dovetailing resources in this way helped reduce wives' dependency on husbands alone.

Miller (1987) emphasized the degree to which husbands assume greater control within marriages but did not address the sensitivity of husbands to soften the assumed responsibility for their wives. As described above, participants in the present study attempted to reinforce the remaining degree of independence in their wives. The focus on control without accounting for potential limits practiced by husbands may be attributable to the sample examined by Miller. Spouses of dementia patients, faced with the overall greater functional losses in their partners as compared to the nature of the health deterioration in the participants' partners in the present study, may be required to assume more responsibility and control. It is helpful to recall that in the present study, the assumption of responsibility by husbands in the marital sphere ranged from minimal (e.g., adopting an attitude of protectiveness concerning one's wife without modifying marital or lifestyle patterns) to heightened levels (e.g., caring for housebound wife suffering from chronic pain) and could fluctuate widely on this continuum. Dementia differs in that the downward trajectory is more predictable and inherently reduces the mental capacity of an inflicted individual to preserve autonomy.

It would be of interest to explore the degree to which husbands of partners with dementia encourage their wives to retain the optimum level of autonomy under their circumstances. In passing, Miller (1987) referred to how many husbands in her sample of six tried to include their cognitively impaired wives in kitchen tasks such as clearing the table and cutting vegetables. She did not expand on this theme in her study. In the specific situation in the present study of the wife suffering the most functional losses, the husband maintained his efforts to encourage the greatest degree of independence in his wife under the circumstances. Other participants also demonstrated flexibility in monitoring their wives' fluctuating capabilities and adjusted their spheres of responsibility accordingly. A similar dynamic may emerge with husbands of dementia patients if it was a consideration in studies.

Erikson and his colleagues (1986) reported that many of their informants depended on their children for assistance. The availability of the adult children helped create a sense of security for the elders which in turn formed the foundation for overall autonomy. In the present study, the sense that participants had of the availability, accessibility, and willingness of others to assist were conditions influencing the decision to request assistance from a particular individual. In outlining the process of dovetailing resources, the safety net characteristics experienced by participants were described. It was noted that the perceived safety net undergirded the efforts of husbands, giving them an additional impetus to maintain marital and individual self-sufficiency. Just the mere knowledge of people to call upon was supportive in that husbands attempted tasks (particularly related to their wives' health care) they may not have otherwise ventured, with the knowledge there was a "back-up" in the event of unforeseen difficulties. Similarly, one factor enabling them to remain in their own homes was the knowledge that neighbors or family were readily available to assist in case of emergency. Therefore, the portrayal of safety net characteristics in the present study seems consistent with the sense of security that is described by Erikson and his associates. Perceptions of a safety net in turn promote a sense of autonomy.

Comparable to the present study, following instances where a family member failed to provide the requested assistance, Erikson and his colleagues observed that their informants rarely blamed the individual. "Although all of the elders in our study praise those forms of assistance that the children *do* provide, few bemoan those that are not forthcoming" (p.206). The authors found that excuses were offered by some informants for these failures while others denied the failures in order to avoid admitting the helplessness this implied for them. In the present study, the explanation put forth for this phenomenon was the low expectations participants held for receiving assistance from others. Perhaps expectations were lowered due to a denial process as suggested by Erikson and his associates. This speculation would require further study.

It is of interest to note in the present study that the wife's increasing dependency was not exactly mirrored by the husband's level of dependency in most instances. The fact that husbands tended to be functionally healthier than their wives may account for this finding. However, a principle is nevertheless raised here. With married individuals, the increased dependency in one partner may precipitate the acknowledgement of tension between self-sufficiency and dependence in the other partner; in this case, the husbands. The reintegration of individual and marital levels in the dovetailing resources BSPP addresses this "unbalancing" within marriages. The husband may still view himself as relatively autonomous through viewing what he can accomplish as an individual. Indeed, he is a resource to his wife which in turn reinforces the notion of individuality and autonomy - he can provide for his partner like no one else ever could. However, at the marital level, husbands recognize the increasing dependence on others, particularly if their wives' health deteriorates further. This increasing dependency may be minimized, however, in view of the relative autonomy retained at the individual level. As stated previously, perhaps requesting assistance for one's wife or the partnership ("she" or "we" versus "I") helps to maintain a greater sense of personal self-sufficiency.

In the present study, several participants voiced their spiritual beliefs and the strength they had drawn from God, their spiritual resource. They described personal relationships that they had formed over the years with God and how the spiritual relationships had deepened. It was noted that for these husbands, their innermost needs were often shared with God rather than other people. That is, if their needs were met on the spiritual plane, they would access other resources accordingly as a component of dovetailing resources.

Erikson and colleagues (1986) did not address spirituality in the psychosocial stage of autonomy versus shame/guilt. Rather, they examined it in the psychosocial stage of trust versus mistrust which harkens back to the beginnings of life. Throughout the life cycle, "the individual struggles to integrate a sense of confidence and belief in the universe, and the relative predictability of its laws, with a discriminating cautiousness and skepticism about the same universe and its realistic unpredictabilities and unreliabilities" (p.218). During life, an individual may commit to an established religion or formulate philosophical approaches to life that address these issues and provide the basis for hope.

In the present study, those participants who expressed spiritual beliefs also spoke of the centrality of the church in their lives. In addition to expressing their religious faith, their social lives often revolved around it. Erikson and his colleagues similarly described the sense of religious commitment and of interpersonal security that some of their informants gathered from their involvement with the church.

In sum, elements of the dovetailing resources BSPP overlap to a degree with the work of others in the caregiving literature. The process is most closely aligned with Erik Erikson's theory of psychosocial development. The main difference concerns the interpersonal emphasis (i.e., relationships with wives) of participants in the present study whereas Erikson's theory is more intrapersonally focused. "Dovetailing resources" is of particular relevance to the tension between self-sufficiency and dependency on others and fleshes out the manner in which the tension is addressed.

Conclusions

In conclusion, the social psychological process of "dovetailing resources" emerged as the basic process whereby the elderly male participants resolved their primary concern regarding how they could best care for their wives. Participants identified themselves as resources to their wives, themselves, and to a lesser extent, others. Similarly, husbands recognized other people with whom they had relationships with and/or the spiritual realm as resources that they could access. In dovetailing these personal and external resources, participants engaged in a decision-making process, balancing what others provided (solicited or unsolicited) or failed to provide with their preference to retain the utmost level of self-sufficiency possible under their unique circumstances. This dynamic was evidenced at both the marital and individual levels and comprises the central theme in the present study.

Influencing the decision-making process are several conditions, most of which are mirrored in the marital and individual levels. However, two conditions which operate predominantly at the individual level are noteworthy. The first pertains to the level of comfort with self-disclosure. Participants were more comfortable requesting personal assistance of an instrumental nature rather than disclosing emotional needs. They generally found it easier to request assistance for their partners or for their more global partnerships than for themselves specifically. In this manner, they preserved a higher degree of self-sufficiency at the individual level. There was a sense that emotional issues that could not be addressed with their wives directly (e.g., anticipated loss of partner) often remained unexpressed. The second noteworthy condition is related to emotional assistance as well in that the participants often drew emotional support from the assistance targeted by others toward their wives. This indirect support, seemingly of an emotional nature more often than not, reduced the likelihood of participants requesting additional assistance. Needs of this type were being met without having to be verbalized.

The central theme of balancing self-sufficiency and dependency is also relevant to the marriages of participants. Husbands described their efforts to ensure that their wives' needs for autonomy were respected as with deteriorating health, wives were often forced to become more dependent on their husbands. Participants expressed sensitivity in this regard by attempting to avoid the assumption of complete responsibility for their wives and marriages. Rather, they tempered the amount of responsibility they assumed and tried to enhance and reinforce their wives' independence to the greatest degree possible.

A second primary theme emerging from the data concerned the level of comfort participants described in nurturing their wives. This comfort may stem in part from extending the levels of assumed responsibility from former employment roles to the home environment. Normative personality changes and/or generativity and intimacy needs may also account for the meaningfulness that husbands attached to their roles as caregivers. Regardless of the proposed explanations however, there was a meshing between the sense each participant had of himself (e.g., self as resource) and the caregiving circumstances as husbands strove to assist their wives to the best of their capabilities.

Coming full circle, the comfort in exercising nurturing behaviors for their wives also enhanced the participant's self-esteem and in turn, their sense of themselves as resources. Each participant stated his satisfaction in doing all that he could to help his wife. Husbands did not downplay their contributions in acknowledging limitations and subsequent reliance on others from time to time. Indeed, several participants realized anew the interdependent nature of life through the process of dovetailing resources in this, the latter stages of their lives.

> It's like the concentric circles ... I think as we age, we get, we get focussed smaller and smaller. We know it all ... we've learned it all and we don't need anymore help. [pause] If anything, I think we need more as age goes on. You realize how little you do know, and then you realize how, how much we're dependent upon other people. (R)

Limitations of Study and Suggestions for Future Research

The conclusions identified above and throughout Chapters IV and V thus far are necessarily restricted to the present study. During the course of conducting this research, several questions arose that could not be addressed adequately within the parameters of the study's focus. Some questions were a function of identifying study limitations in light of interviewing only one group of people (i.e., husbands). Other questions arose in the process of analyzing data as emergent themes and phenomena "sparked" related curiosities that would have been of interest to pursue but were academically nonadvisable (i.e., my need to graduate!). In this section, limitations of the study and suggestions for future research are intertwined.

In the process of analyzing data, I felt there was some injustice done to recognizing the wholeness of participants' lives. It was difficult at times to continually abstract themes and theoretical codes as these analytical procedures resulted in the inevitable loss of the full scope of individual lives. Conrad (1990, p.1258) voiced similar criticism of grounded theory methodology: "In our search for conceptual themes and meaning, our analytic method 'shatters' and disembodies data from the individuals who produce it. How much of the narrative lifeworld do we sacrifice to create a meaningful sociological world?" He goes on to recognize that a greater emphasis on narrative may respect data integrity but trades off gains in this regard with reduced analytic generalizability afforded by grounded theory. Clearly, this is a difficult issue to resolve and researchers continuously negotiate such issues in selecting areas of interest and research paradigms. In regard to the present study, it would be of interest to examine the research question with a hermeneutic or similar methodological approach to capture a greater proportion of each participant's life narrative.

One of my initial impressions, continually reinforced during the study, was the resoluteness of the participants to care for their partners. They steadfastly believed that if the circumstances were reversed, their spouses would undertake for them in a similar fashion. Their convictions about teamwork were based on a marital historical foundation which had endured and grown through the passage of over four decades of married life. It was noted that while participants were heterogeneous in many respects, their marital histories were comparably homogeneous. For example, all counted at least 40 years of marriage and had been married once. Future research could address different marital histories in these regards. Would the process of dovetailing resources be different for husbands in their second - or third, etc. - marriages? At the very least, a husband's informal social networks would be more diverse with combinations of family relationships. Circles of friends could also be affected through marital status changes. Would remarried husbands be as apt to assume as much/less responsibility in caring for their wives under such considerations? Would the process be affected by the circumstances (e.g., widowed or divorced) surrounding the dissolution of a prior marriage?

In contrast to well-established partnerships wherein the partners individually and jointly receive unsolicited assistance from other people, would recently married older couples receive comparable levels of unsolicited assistance? Would the inclination to access external resources be affected by marriage length? In the present study, participants demonstrated their resolve to maintain as much independence, maritally and individually, as possible. With a shorter marital history, might husbands be more/less prone to solicit help because they do not know their partners as well as husbands in marriages of longer duration?

The observed level of commitment and strength of beliefs in marriage as an institution may be partially attributable to cohort effects. Certainly, people currently over 65 are less predisposed toward breaking marriage vows than younger cohorts. Amongst elderly married couples, divorce rates of 2.2 per 1,000 are much lower than younger age groups with rates of 40 per 1,000 (Chappell, 1992). The cohort of elderly men and women generally hold strongly adhered beliefs in the sanctity of marriage as an institution. As espoused by one participant:

> I think that we've got to put more emphasis on the significance and meaning of a marriage, of a husband and a wife where the two become one. How important that is. Today, marriage, I hope I'm wrong but it almost appears as though two people get married for convenience sake. They, they go on separate vacations, they can have little contracts they write out; the two aren't one at all ... But two people have got to become

> one. One in the sight of God and in the sight of man too ... Each year they become closer together and more understanding of each other. (R)

Will future cohorts approach marriage in the same way? Chappell notes that divorce rates are increasing for all age groups. It remains to be seen what effects changing beliefs about marriage commitment will have in regard to caregiving. With health deterioration concomitant with the aging process, will future husbands be as willing to provide care to their wives?

The current cohort has had relatively limited exposure to formal networks. Will future elderly husbands, who have witnessed greater acceptance and even reliance on health care professionals, be more apt to seek out such services - to be less self-reliant than evidenced in the present study? The apparent reluctance of the elderly participants to disclose emotionally-laden information with others may also be affected in the future by mores of today. Are younger men more willing to express vulnerabilities than these men were at similar ages? Is it more permissible for men to do this as we close out the twentieth century in comparison to the dawn of this century?

While it could have been expected that elderly men would adhere to stereotypically held masculine roles of self-sufficiency, the degree to which they did so was perhaps weaker than expected. As described in the analysis, their preference was to retain as much independence as possible at both the marital and individual levels. However, when encountering self-sufficiency barriers, there were few expressions of discomfort in requesting assistance. Could this general flexibility be attributed to personality or developmental characteristics? That is, were these men as willing to ask for help when they were younger?

A further area of interest is in the identification of self as a resource. There is an implication in doing so that the participants had relatively high levels of self-confidence and self-esteem. Would husbands with lower self-confidence and self-esteem be as willing to tackle responsibilities for caring for their wives and/or themselves? Would such husbands be more/less likely to become dependent upon other people with whom they have established relationships, in formal and/or informal circles? What personality characteristics are consistent with assuming responsibility in these ways?

As identified previously, one limitation of the present study is the reliance upon the perceptions of participants. Particularly in the areas of indirect support and unsolicited assistance, it would be of interest to determine the perspectives of the providers. This could shed further light in the area of indirect support on the degree to which others view their targeted assistance as directed toward wives rather than husbands. Perhaps there is a greater desire and awareness on the part of other people concerning the plight of husbands than husbands are aware of. In regard to unsolicited assistance, it is conceivable that husbands unintentionally request assistance through, for example, nonverbal communication. They may not be aware of the indirect signals they are sending to others in regard to needs for assistance. In gaining the perspectives of the providers of assistance, the communication patterns regarding the request, or non-request, of assistance could be clarified. One methodology that could be particularly helpful in this regard would be participant observation. Obviously, ethical concerns would limit the extent to which this could be pursued.

One of the conditions influencing the decision to request assistance was the extent of indirect support perceived by husbands. On the basis of the descriptions by husbands, it appeared that they gained support indirectly through the efforts of others assisting their wives. As husbands solicited emotional support infrequently in comparison to instrumental types of assistance, it would be of interest to explore this phenomenon further. Is the solicitation of emotional support related to the amount of indirect support perceived by husbands? How pervasive is indirect support in the lives of elderly men? To what degree do they misconstrue the attributions of others?

Other studies have examined male-female differences in regard to the receipt of assistance from others and contact with social network members. For example, husband caregivers have been found to be more likely to incorporate assistance from outside the home than wife caregivers of elders with chronic functional limitations (Stoller & Cutler, 1992) and more situational limitations associated with temporary cancer treatment experiences (Allen, 1994). However, the process by which husbands and wives undertake their responsibilities for their frail spouses have received scant attention. It would be informative to explore how elderly wives view changes in their relationships following the deterioration of their husband's health. Do women experience a process similar to dovetailing resources? Are they more/less apt to strive for self-sufficiency? Do they differentiate between marital and individual levels? Do they engage in self-care as well and if so, how? Can the dovetailing resources process be applied to other life cycle events for women (and men) of younger and older ages?

Husbands may be more inclined than wives of frail elderly spouses to identify their spouse as a resource. Research suggests men have more limited network structures than women. Antonucci and Akiyama (1987) summarized the social support literature as suggesting that for men, network structures consist "predominantly of a single person, the wife, who performs most support functions for them" (p.738). They cautioned that the literature is inconsistent in this portrayal, perhaps reflecting diverse social support definitions. However, if one assumes that there is validity in the tendency of men to identify their wives as their primary source of support, it is consistent with the present study's finding that husbands identify their wives as resources. Partner health deterioration may affect their identification of their wives as resources less frequently than if the situation was reversed. Women have broader social networks and can therefore access more external resources rather than rely more heavily on their husbands as a resource. Thus husbands, because of their more limited number of supportive relationships, may be more inclined than women to rely on their partners, to identify them as resources. Regardless, it would still be of interest to determine if the dovetailing process differs between men and women in terms of the level of acceptance/reluctance in accessing external resources.

Antonucci and Akiyama (1987) observed in their study of people aged 50 and over that men were more likely to receive support from, and provide support to, their spouses. Women were conversely more likely to report the receipt and provision of support to others such as children and friends. Their operational definition and measurement of support may account for this discrepancy as it focused on more emotional than instrumental aspects (i.e., receiving and providing: confiding, reassurance, respect, sick care, talk when upset, and talk about health). A higher proportion of men than women reported relying on spouses as opposed to children and friends for these types of support. Their results suggest that men may be more likely to prefer to maintain marital self-sufficiency as they are drawn more strongly to the marital relationship. A comparative study could determine if this is the case.

Another issue pertaining to gender is also identified in the interactive process of conducting qualitative research of this nature. The question arises as to the degree to which my gender influenced the descriptions of the participants' experiences. The BSPP in the present study is largely cognitive in nature. If the interviewer and/or researcher were female, would the model have looked any different? For example, would there have been a stronger affective component? Future research could address the potential gender interaction between researcher and participant.

A longitudinal study spanning several years could be helpful in determining how the BSPP of dovetailing resources is affected over time. The study by Erikson and his colleagues (1986) addressed autonomy issues and other psychosocial stages with a sample of older people than that in the present study. As the purposes of the studies were different, comparisons are considered cautiously. However, because old age is so heterogeneous, it would be helpful to follow-up adults from "young" old-age (i.e., early 60's) to "old" old-age (i.e., 90's). Conrad (1990) advocated the usefulness of multiple interviews as opposed to single interviews with participants. The present study's procedure incorporated two interviews in addition to retrospective descriptions but the findings still frame a snapshot of only a few months duration in the lives of the participants. More follow-up interviews with participants conducted over a longer time frame could more accurately capture and highlight change. In particular, change in the decision-making processes associated with health deterioration or other factors could be examined more closely. Different conditions could perhaps be identified along with subtle nuances in the processes if participants were interviewed over a span of two years or more for example.

A longitudinal study would also be of benefit in addressing bereavement issues prospectively. During the course of the present study, several wives died and although it was beyond the scope of the study's focus, it was noted that the grieving process of the two participants interviewed subsequently was varied. To what degree do relationships affect the bereavement process? How are relationships changed as a result of the partner's death? These husbands aligned their identities predominantly within the husband role and with the loss of the focused relationships with their wives, it is of interest to study the effects on other relationships. Are widowers more/less inclined to seek assistance of any type - including emotional support - in comparison to their former married years? Does unsolicited assistance vary after such an event and how does the loss of indirect support affect the husbands? Over time, do they begin to interact less, or more, with the people with whom they have had relationships? Are there factors in current relationships that predispose a husband's predilection toward accessing external resources while grieving?

Participants in the present study identified their wives as resources, as being in a position to assist both themselves (that is the wives) and husbands. Most caregiving studies have focused on the limitations of elderly people with dementia and have identified stressors related to behavioral changes, speech repetition, and memory loss; stressors rarely associated with cancer patients. Under such conditions, it may be difficult to identify strengths in partners. Comparative studies could determine how influential cognitive skills are to perceptions of caregivers in this regard. Although not evident in the present study, cognitive function can be affected by brain metastasis or brain tumors and a comparative study focusing on the effects of cognitive functioning, as opposed to other physiological declines, may be instructive in determining the effects of health deterioration on marital and other relationships.

Implications for Helping Professionals

As noted in the first chapter, elderly husbands of cancer patients seldom present for support services. Most participants in the present study dismissed the need to seek assistance from formal services as their needs were currently being addressed. The findings of the present study suggest they may avoid services due to their preference for self-reliance. This is consistent with Barusch's (1988) observation that spouse caregivers are most often satisfied with actions to change problematic situations on their own. They are therefore reluctant to seek or accept assistance.

An alternative explanation for the low numbers of elderly husbands participating in support services is a lack of knowledge about services. Of the three participants in the present study who acknowledged the potential benefit in accessing formal resources, only one had any knowledge of the existing services and how to access them. All of the participants were familiar to some degree with medical services available to them and most had been personally exposed to the health care system at some point in their lives. In contrast, few of the participants had experience with, or knowledge of, auxiliary services (e.g., home care, domestic assistance, social work, psychology, etc.). Therefore, physicians and nurses would seem to play an important gatekeeper role in alerting husbands of the availability of such services. To address the lack of knowledge, service providers could inform men of the availability and the nature of the services. Elderly men in particular, with their limited exposure to formal systems, may have very limited awareness of the availability of services to them as "nonpatients."

Several participants were confused about the roles they played within the formal realm of their wives' care. Some felt somewhat ostracized by their wives' health care team but they also acknowledged that they did not always articulate their concerns with the personnel. Not surprisingly, there was a broad continuum of participant involvement with the formal system. Some husbands were actively involved and often present with their wives during appointments because of the requests of their partners and/or medical personnel. Others believed that their wives' health conditions were of a private matter and therefore infrequently accompanied their wives into examination rooms or had direct contact with health care personnel. For those who do not accompany their partners, it would be a disservice to assume that they are not interested in the welfare of their wives simply because they remain seated in the waiting room while their wives are attended to. Both patients and spouses, particularly of this cohort, could operate under the assumption that patient matters are necessarily private affairs, managed without an option for a more collaborative approach with the spouse and/or family.

It is cautioned that I am not advocating that all husbands should be personally invited by health care personnel to accompany their partners for medical examinations. Patient confidentiality must be respected and therefore, patients could be informed of this possibility initially. Patients could then determine whether they were comfortable with the prospect of having their husbands accompany them for all, some, or none of the appointments with health care personnel. Patients could also be informed and provided with written information concerning programs available to their spouses. By offering to include husbands in these ways, husbands may view themselves more as a resource to their wives - and to the health care system. This could in turn enhance their self esteem. At the very least, husbands could be provided the opportunity to be as involved in formal health care as they and their partners desire.

Given the value participants placed on the assumption of responsibility, it is suggested that in offering services, health care personnel be sensitive toward gearing services around the notion of supplementing the husbands' efforts without usurping their roles. In their accounts of requesting assistance, participants never gave the impression that they wanted to relinquish their roles or abdicate their responsibilities. The results of the present study and those of Motenko (1988) suggest husbands do not want someone else to take over but rather, they prefer ongoing supports enabling them to continue their primary tasks. Barusch (1988) similarly noted that formal service providers to spouse caregivers of frail elderly persons must carefully attend to the spouse's preference for personal control.

It cannot be assumed that in requesting assistance for a wife, the husband is also requesting assistance for himself. It is recalled that there are differences and similarities between marital and the individual levels. By a service provider responding appropriately at the marital level and providing help to a wife, the husband may still retain his sense of responsibility and furthermore, derive indirect support. In meeting a need at the marital level, personnel may also be opening the door for future involvement at the individual level. In short, health care personnel need to be aware of the need to make their foreign territory more hospitable to husbands - without assuming all husbands need help. As several participants emphasized, they receive adequate support through their relationships with family, friends, and neighbors and therefore do not desire further assistance.

Husbands may be reluctant to disclose personal concerns because they perceive their concerns as insignificant in comparison to their wives' difficulties. Personnel need to be wary of the potential for discouraging the discussion of a husband's "minimal" concerns as husbands may be reluctant to voice any concerns. Any initiatives may therefore be preliminary enquiries that could lead to further and more personal disclosures. Husbands may also be learning the medical system and therefore may be addressing their concerns to the wrong personnel and simply need to be redirected rather than dismissed.

As evidenced in participants undergoing prolonged crises associated with their wives' health, husbands may ignore their own well-being. Health care personnel could enquire into a husband's well-being, identifying somatic and other indicators of stress and normalizing the experiences as consistent with other people in similar circumstances. Elderly husbands may be more prone to discuss physiological problems than mental symptoms of distress but personnel could normalize emotional reactions associated with witnessing a loved one suffer. Sensitivity should be exercised in that husbands may not express their feelings as openly in the presence of their wives because of their propensity to undertake a protective function of their wives and to appear "strong" and "positive." Lichtman and colleagues (1987) also identified the need for sensitivity in this regard. Anxieties about recurrence, death, and wives' feelings which were expressed privately by husbands to these researchers were usually not shared with their wives.

One of the areas identified as most difficult for participants to manage was the realm of emotional communication with their wives. This was evidenced in the discomfort most felt in discussing death with their wives and their general preference for providing instrumental as opposed to affective support. Participants expressed discomfort with emotional or mortality issues and were generally inclined to gloss over their wives' concerns (at least as best can be determined on the basis of their accounts). Instead, participants endeavored to instill their strength in their partners and to promote a positive attitude. This tendency has been observed in other studies as well. Lichtman and associates (1987) found that significant others of breast cancer patients avoided expressing negative attitudes because of their belief that doing so was in the patient's best interest.

It should not be assumed that all husbands need or desire to be more comfortable with the concomitant emotional affects of giving care but perhaps it can be reframed as "work" of a different nature. Because wives were not interviewed, it was impossible to ascertain in the present study whether wives desired greater involvement of their husbands in this capacity. However, Lichtman and colleagues (1987) suggested in their study that "couples who express their realistic concerns - such as the possibility of recurrence or death - and appear to be sensitive to each other's emotions and concerns show better marital adjustment than couples who do not express these concerns" (p.66). In helping men who request such assistance or in working with couples, it could be beneficial to empathize with their helplessness and the benefit of just "being there," holding hands, and/or quietly listening. Especially for husbands intent on "doing" things for their wives, such an approach could legitimize that they are in fact "doing" something worthwhile and valuable for their partners.

Husbands could be reinforced for recognizing the need to promote independence in their wives and ways in which their wives still contribute to their partnerships. In the present study, participants expressed an awareness of the importance in encouraging their wives in this fashion. However, without interviewing the wives, it is again impossible to ascertain the degree of success in this regard. Health care personnel could also be sensitive about issues of autonomy and dependency and determine the comfort levels of both partners in the distribution of dependence and independence.

Finally, the type of assistance made available to husbands is also an important consideration. In Miller's (1987) study, husbands of cognitively impaired partners were rarely interested in attending support groups. They indicated their preference for participation in activities apart from their family situation. In the present study, two participants specified their desire to participate in support groups where spouses could voice their concerns and learn from each other. Other participants were not interested in attending such groups because they were comfortable with the support they received via their existing relationships. Clearly, support groups were not viewed as panaceas by all of the participants but some may be interested and feel they could gain some benefit. Again, advertising the availability of such groups, as with other services, is imperative given the elderly husband's relatively low level of awareness of service availability to them personally.

The specific form of assistance provided to husbands may not be as crucial as the simple recognition of the impact the wife's health deterioration has on them. Health care providers could go a long way toward assisting husbands by acknowledging the possibility that they may benefit from some attention and help.

> The caregiver should be given some interest, you see. They're [other people] so concerned about the one that's in the hospital, well I can see that that's certainly, it's nice when they're doing that ... but realizing that that caregiver needs extra help, that it's not just the one that's sick you see. (T)

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Appendix A

INFORMATION SHEET

Project Title: Husbands of Cancer Patients: Experiences with Social Networks

Investigator: Keith Carlson, Ph.D. Candidate (463-9395)
I am a chartered psychologist and doctoral candidate at the U. of A. In August, 1992, I finished a one year internship in the Department of Psychology at the Cross Cancer Institute. I selected my research topic because of previous experiences (personally and professionally) with cancer patients and their families as well as my interests in working with elderly people.

Characteristics of People to be Interviewed: If you are a retired male over 65 years of age and your wife has been diagnosed with metastatic cancer, I am requesting that you consider participating in this project.

Purpose and Description of Study: While researchers have focused on cancer patients, they have only recently begun to examine the impact of cancer on family members. I am interested in any effects your wife's cancer may have had on you. More specifically, I am interested in any changes you may have noticed in your relationships with your wife, family members, friends, and others. I will be asking questions such as: "How has your life been different since your wife's cancer diagnosis and treatment, if at all?" and "What changes have you noticed in your relationship with your wife?"

Please contact me at the number above as I would be happy to discuss the project with you and answer any questions you may have. If you agree to talk with me further, an appointment will be scheduled to meet at the location of your choice. You are being asked to volunteer to meet with me at least twice. Each interview will be approximately one hour long and will be audio-recorded and transcribed. You may review the transcribed interviews to ensure accuracy and may add comments for clarification and elaboration. During your involvement in the project, you may be asked for your impressions regarding the emerging results of the study. You will also be given the opportunity to read a summary of the research results.

You can refuse to answer any question during the interview or choose to withdraw from the project at any time without providing any reason for doing so. Your decision to participate or not has no bearing on the care your wife receives or the services you may be receiving.

I guarantee your anonymity in all records and reports. All information is kept confidential and at the end of the research project, all audio-tapes will be erased. No names will appear on any written or verbal presentation of the research.

Appendix B

CONSENT FORM FOR PARTICIPANTS FROM CANADIAN CANCER SOCIETY

Project Title: Husbands of Cancer Patients: Experiences with Social Networks

Investigator: Keith Carlson, Ph.D. Candidate (463-9395)

Thesis Supervisor: Dr. D. Sawatzky
Department of Educational Psychology, U. of A.

Purpose of Study: The purpose of this study is to develop a more thorough understanding of the experiences of elderly husbands of partners with metastatic cancer. Husbands will be interviewed and asked to describe their experiences pertaining to their interactions with spouses, family members, friends, and health care professionals. It is anticipated that the information that is provided will be helpful to other spouses in similar circumstances as well as helping professionals.

THIS IS TO CERTIFY THAT I, ______________________, hereby agree to volunteer to participate in the research study described above. The study has been explained to me and I understand that:

- I will be interviewed on at least two occasions.
- I will be asked to review the results occasionally to offer feedback.
- Interview lengths will vary but the average length will be one hour.
- I may refuse to answer any question at any time.
- Interviews will be audio-recorded and I will have an opportunity to review the transcriptions to ensure accuracy.
- I may add relevant information to the transcripts to clarify or expand on my experiences.
- I can withdraw from the study at any time without adverse effects on the care received by my wife and/or myself.
- All information is confidential and instead of my name appearing on any copy of written reports, a pseudonym will be used.
- All audio-recordings will be erased upon completion of the study.
- I will be given an opportunity to see a summary of the final report.

I have had an opportunity to ask any questions about the study and understand that I am free to ask further questions throughout the project.

______________________	______________________
Participant	Researcher
______________________	______________________
Witness	Date

Appendix C

CONSENT FORM FOR PARTICIPANTS FROM REGIONAL CANCER TREATMENT AND RESEARCH CENTRE

Page 1 of three

The Psychosocial Process of Interacting with Social Networks: Perspectives of Elderly Husbands of Cancer Patients
(An Examination of Relationships and their Impact on Husbands of Cancer Patients)

CONSENT FORM

This consent form, a copy of which has been given to you, is only a part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

I am a psychologist and doctoral candidate at the University of Alberta. In August, 1992, I finished a one year internship in the Department of Psychology at the Cross Cancer Institute. I selected my research topic because of previous experiences (personally and professionally) with cancer patients and their families as well as my interests in working with elderly people.

Purpose and Description of Study: Two developing trends will have a significant impact on increasing numbers of elderly men in the future. First, the incidence of cancer in females is increasing. Secondly, there is a trend toward out-patient treatment that may be complemented by home care. Researchers have only recently begun to examine the impact of cancer on husbands of cancer patients. The purpose of this study is to develop a more thorough understanding of the nature of relationships for elderly husbands of partners with metastatic cancer (the cancer cells have spread from the original tumor to other parts of the body). More specifically, the study will address relationships between husbands and their wives, family, friends, and health care providers. You will be asked questions such as: "I'd like to know about how things have been since your wife was diagnosed with cancer. Could you tell me if your life has been different since your wife's cancer diagnosis and treatment, if at all?" "Have any changes occured in your relationships with your family members, and if so, could you describe the changes?" It is anticipated that the obtained information will be helpful to other spouses in similar circumstances as well as to helping professionals who provide services for family members of cancer patients.

Participant's Initials________ Date__________

Your requested involvement: You will be contacted in a few days after you have received this form and have had an opportunity to think about the study further. The project will be discussed and any questions you may have will be addressed. If you indicate a willingness to volunteer for this project, an appointment will be scheduled to meet at a place of your convenience. You are being asked to meet with the investigator for an interview on at least two occasions over approximately 4 - 8 weeks. Interviews will be audio-recorded and although interview lengths will vary, it is anticipated that they will be approximately one to one and a half hours long. The interviews will be transcribed and you will be requested to review the transcriptions to ensure accuracy. Further, you will have the opportunity to add comments on the transcriptions for further clarification and elaboration. During your involvement in the project, you may be asked for your impressions regarding the emerging results of the study. You will also be given the opportunity to have a summary of the research results.

You can refuse to answer any question during the interview or choose to withdraw from the project at any time without providing any reason for doing so. Your decision to participate or not has no bearing on the health care your wife receives or the services you may be receiving at the Cross Cancer Institute.

Your anonymity is guaranteed as your name will not appear in any transcript or report of the results. Another name or pseudonym selected by you will be used in all transcripts. All information is kept strictly confidential and interview transcripts will only be seen by researchers involved in this study. Transcripts and taped interviews will be stored in a locked cabinet. The tapes will be erased at the end of the study while the transcripts will be kept indefinitely for possible future analysis.

Participation in this study may be of no personal benefit to you. However, based on the experiences of other people involved in similar types of research projects, you may derive benefits such as the support and validation of your experiences. It is hoped that, in the long term, services for spouses of cancer patients can be improved based in part on the results of this study.

Understanding of Participants

My signature on this form indicates that I have understood to my satisfaction the information regarding my participation in the research project, and agree to participate as a subject. In no way does this waive my legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities.

Participant's Initials________ Date__________

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I am free to withdraw from the study at any time without jeopardizing my spouse's health care. My continued participation will be as informed as my initial consent, so I am free to ask for clarification or new information throughout my participation.

I understand that Keith Carlson at 463-9395 or 492-0898 (Cross Cancer Institute) or Dr. M. Handman (Director of Psychology, Cross Cancer Institute, 492-8703) will answer any questions that I have about the research project.

If at any time during the course of this study I feel that I have been inadequately informed of the risks, benefits, or alternatives, or that I have been encouraged to continue in this study beyond my wish to do so, I can contact the Patient Advocate at (403) 492-8585.

A copy of this consent form will be given to me to keep for my records and future reference.

________________________ Name of Participant	________________________ Signature of Participant
________________________ Name of Witness	________________________ Signature of Witness
________________________ Name of Investigator	________________________ Signature of Investigator

____

Date

Appendix D

DEMOGRAPHIC DATA

Pseudonym____________

	Participant	Spouse
Age	______	______
Education	______	______
Employment	______	______

Length of Marriage ____________

Number of Children ____________

Residents of Edmonton ____

Residence of other children ____________ ____________ ____________

Patients' Diagnosis ____

Date of Diagnosis ____

Treatment History and Dates

____

____

____

Prognosis (if known) ____

____

Participant's description of personal health __________________________

____