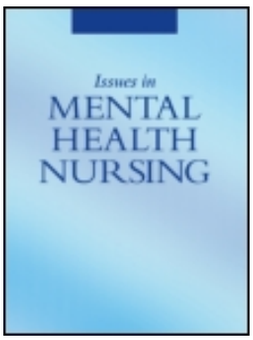

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BEHIND THE SCENES: SPOUSAL COPING FOLLOWING PERMANENTLY DISABLING INJURY OF FARMERS

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Hidden within the pastoral setting of rural America are the struggles of farm families who must cope with a decreasing economy, increasing technology, and one of the highest injury rates of any industry. Wives of farmers often juggle household responsibilities, hold an off-farm job, and work on the farm. Too often, wives are first on the scene of a serious injury to their spouses. All attention is focused on the farmer but the wife must cope with caregiving, her usual work, and the added full responsibility of the farm. This grounded theory study examined the process of spousal coping after a permanently disabling injury occurred to their farmer husbands. Interviews conducted with 12 farm wives elicited four themes in the coping process. These findings may help identify critical points of mental stress and form interventions to assist spouses of injured farmers in their adjustment to changing roles and responsibilities.

You know, it's getting dark, it's odd that he's not in here yet . . . Maybe I better go check on him. So I got in the truck and drove . . . two fields back . . . there were no lights . . . but I saw the header . . . I saw that turning and I drove around in the front . . . he was caught under it . . . he was waist up . . . leaning out to talk to me . . . it was just horrible.

This story and others like it recount the experiences of farm wives who were first on the scene to find their husbands severely injured in farm

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accidents. Such traumatic events were only the beginning for farm wives who, with their husbands, faced the struggles of recovery and adjustment following permanently disabling injuries. The purpose of this study was to identify the coping process of farm wives whose husbands suffered permanently disabling injuries while farming and to describe spousal roles and adjustment after this traumatic event.

BACKGROUND

Farming ranks consistently among the top three most hazardous industries for work-related injuries in the United States (National Safety Council, 1999). Massive machinery, long hours, and the solitary nature of family farming contribute to the occupational hazards associated with agriculture. Nearly 12 million persons are engaged in some form of agricultural production, and 140,000 of them suffer a disabling injury each year. Merchant (1991) predicted that half of those injuries resulted in permanent disabilities. One surveillance investigation revealed that the severity of farm injuries greatly surpasses injuries received by the general population (Auslander, 1994). The prevalence of permanent disability is grossly underestimated because 95% of U.S. farms are exempt from the Occupational Safety and Health Administration (OSHA) regulations and injury rates are based on voluntary reporting from 35 states (Baker, O'Neill, Ginsburg, & Gupa, 1992; National Safety Council, 1999).

In a study of farmers with upper-extremity losses, Reed (1996) found evidence that the impact of such a devastating injury on spouses deserved study. Amputee farmers verbalized that the impact of injury was as serious, if not more serious, for their spouses than for themselves. Spouses and family members echoed this through expressions such as "this is a family thing that happens. We've all been through it" and "so we're not just talking about his loss, we're talking about both." One farmer realized quickly after the injury, "This has not only been a trauma situation for me . . . it has hurt all of us." Little is known about spousal coping following a permanently disabling injury to a mate. Injured individuals report that their spouses provide the most assistance during the recovery process. Few studies have addressed the impact that the event and the adjustment process have on the spouses, focusing instead on the impact of the spouse in the recovery of the ill or injured person (Bennett, 1993; Owen, 1987). Recent literature offers that major changes in family structure are necessary to meet the requirements for care of a person with a permanent disability (Leske & Jiricka, 1998). The spouse is the significant family member usually responsible for

decision-making immediately after a critical injury. Studies of spouses of persons who suffer cardiac events reveal that spouses report higher stress levels than the patients (Miller & Wickoff, 1989). In a study of spouses of persons with mild traumatic brain injury, Rosenburg (1998) found that one-half the spouses reported adverse effects on their marital relationships. Disabling injuries and the subsequent outcomes of such injuries significantly impact spouses' lives. Medical care, coping strategies, and concerns for psychological and social well-being are directed toward the injured person following a critical disabling injury. Health care professionals as well as concerned family members, friends, and the community often overlook the needs of spouses.

Historically, the term "rural" was used to describe a place with sparse population and total dependence on agriculture (Buttel, Olaf, & Gillespie, 1990). Today the concept is more complex, as noted by Brown and Herrick (2002). For the purposes of this paper, "rural" is taken to mean the agricultural economic base, specifically farming operations.

Rural families, especially those who reside on farms, live independent lives, often at great distances from organized programs of health care and social support. Isolation, distance, and cultural differences may preclude their participation in formal rehabilitation programs and support groups (Bushy, 2000; Lee, 1998; Reed, 1993, 1996, 1997; Reed & Claunch, 1998). Time needed to travel to participate in such events must be balanced against the impact such time loss has on farm work. Cost, in terms of both time and money, may be beyond the reach of many farm families. When illness or injury strikes, the family relies on itself rather than on predesigned programs. The farm family sees itself as a private unit: it can take care of its own (Bushy, 2000; Garkovich, Bokemeier, & Foote, 1995). Although it may not make sense to outsiders, this cultural independence is the essence of the historical survival of farmers (Butterworth, 1992; England, Gibbons, & Johnson, 1979).

This study involves a rural population whose health is rarely spoken about. As part of the farm family, farm wives generally adopt the rural concepts of farm culture, beliefs, and agrarianism. Understanding the life constraints, belief systems, and environmental context of the rural client is essential if health care needs are to be met effectively (Bushy, 2000; Stein, 1982). Rural women in the United States exhibit lower levels of education, income, health insurance coverage, and health seeking behaviors than their urban counterparts (The Rural Women's Work Group and the Committee on Rural Health of the American Psychological Association, 2000). In contrast, rural women are twice as likely to be depressed or anxious and exhibit higher rates of suicide than urban women. Rural farm women also are more likely to work a "third shift,"

i.e., an off-farm job, household duties, and a third shift of farm work (Gallager & Delworth, 1993). The cultural stigma of mental health problems and the role expectations of women who reside in farm households, coupled with the unexpected burden of serious traumatic injury to the head of household, create a critical time in the life of the farm wife.

METHOD

Design

Grounded theory methods were used to guide this qualitative study. Grounded theory is used to discover a basic social process conveyed in psychosocial symbols (Chenitz & Swanson, 1986). It is useful in areas where little research has been done, as it allows constant comparative analysis of the data in order to generate hypotheses and formulate theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Constant comparative analysis is crucial to the grounded theory method, immersing the investigator in the world of the participant, facilitating identification of salient variables, and affording the opportunity to clarify and expand one's understanding of the data (Chenitz & Swanson, 1986; Glaser, 1978; Glaser & Strauss, 1967; Patton, 1990). The data are analyzed individually and then compared across interviews to identify categories of meaning. The data are continually revisited as the study progresses and a deeper understanding of the phenomenon emerges.

Sample

Twelve wives of permanently disabled farmers participated in the study. The participants were recruited through contacts of the researcher with the agricultural community and AgrAbility Projects throughout the United States (AgrAbility is a United States Department of Agriculture service project that assists farmers with disabilities). The farm wives were gleaned primarily from the population of farmers who participated in Reed's previous studies of farmers with upper and lower extremity amputations (Reed, 1996, 1997). The study included farm wives from Kentucky, Tennessee, and Iowa. Ages ranged from 21 to 70 years. Only two of the wives had not grown up in a rural farm setting; however, the majority indicated that they had participated very little in actual farm work at the time of their husbands' injuries. The types of disabilities all involved lower-extremity and upper-extremity amputations. All the injuries but one were directly related to farm work and ten of the husbands

were engaged in farming as their primary occupation. Grain and cattle operations were the primary types of farming. Only one spouse in the study was not married to the farmer when the injury occurred but she was dating the farmer at the time of the injury. For the remainder of the participants, the length of the marriage at the time of injury ranged from one year to over 50 years. The participants all reported their marriages were "strong" before the injury. At the date of the interviews, the elapsed time since the injury ranged from 1 year to 18 years (mean = 5.67 years), with the majority of injuries occurring from 1 to 5 years prior to the interviews.

Procedure

Data were collected over a 6-month period from August 1997 through January 1998. Individual interviews ($N = 9$) and one focus group were structured to elicit data from farm wives on how they responded after their husbands were injured and to identify the extended impact of the injury on the family. Two spouses were interviewed in the presence of their husbands, seven were interviewed privately, and three were interviewed in a focus group. Initial interviews conducted with the husbands present seemed to inhibit the wives from expressing all their thoughts and feelings. Recognizing this restricting atmosphere, future interviews were arranged with the wives alone. The focus group was conducted for time and convenience during a family-oriented conference for farmers with amputations and yielded the most open and expressive responses in the study. The interviews, each lasting two to three hours, were audiotaped and transcribed verbatim. Personal identifiers were removed from the transcriptions.

In addition to individual interview and focus group data, grounded theory incorporates a variety of mechanisms to enhance understanding of the phenomenon under study. Field notes and personal observations provided supplementary data. When interviews were conducted in the farm home, the interviewer often had the additional luxury of touring the farmstead. Such opportunities increased understanding of farm operations and spousal roles. These mechanisms also lend support to the trustworthiness and credibility of the study. Field journals, memos, and analytical diaries contain threads of insight that are woven within the analysis to unfold the theory. These ancillary data kept by the interviewers were used to frame a deeper understanding of the process of coping.

Data were open-coded and analyzed using the constant comparative method of analysis (Glaser, 1992). Two readers coded the data independently and compared coding. Agreement was greater than 95% on the basic social process of spousal coping. A coding dictionary was

developed based on content after the first two interviews and guided analysis thereafter. The iterative process of data analysis incorporates both inductive and deductive approaches to theory development. The inductive component (substantive coding) is used to identify variables and concepts and derived themes from the data, while deductive reasoning (theoretical coding) allows generation of hypotheses from the concepts. Substantive codes were developed during the initial coding process, and were then combined into theoretical codes in order to formulate a rudimentary process of spousal coping.

Upon completion of interviews with the 12 wives identified through previous studies, sampling for this preliminary study ceased. No new data were discovered in the last interviews, indicating saturation for this sample. The purpose of this study was to discover a basic social process that guides spouses in coping after serious injury to their husbands. Findings are presented as a basic model, not as a developed theory.

FINDINGS

Four major themes were identified that guided spousal coping after the farmer's injury: survival, sheltering, sacrifice, and stabilization. Table 1 illustrates the characteristics of each of these four themes.

Survival

In each of the interviews, the immediate concern of the spouse was for the farmer's survival. First reactions were to do whatever was necessary to keep the farmer alive. Four of the 12 farm wives were the first person on the scene of the accident and had to respond immediately to the grim circumstances they confronted.

TABLE 1. Themes of Spousal Adjustment

Theme	Characteristics
Survival	Willingness to do whatever is necessary to keep the farmer alive and going
Sheltering	Protective behavior pattern toward the farmer Suppression of feelings
Sacrifice	Perception that only one person's needs can be met and that the farmer's needs must come first
Stabilization	A new resolve and awareness reflected by spouse's return to social activities and the assertion of independence

> When I saw him in the baler I thought he was dead . . . but his little head moved.
>
> He came in . . . he looked like one of the horror movies where the blood runs down the face.

Immediate actions of the wives took the form of calling 911, contacting friends and family for help, placing the unattached limb in a cooler, and taking the injured farmer to the hospital. Standing by and watching others work to rescue their husband played havoc with the wives' emotions.

> It seemed like every minute was an hour . . . trying to make the right decision and do it fast.
>
> We had the paramedics and the rescue squad and everybody . . . no one knew how to get him out.
>
> All I was thinking about [was] is he going to live or die.

After arriving at the hospital, the battle for survival continued. Medical facts and the potential for complications from the injury increased the women's fears that their husbands might not survive.

> In the hospital setting I was having to be meeting with people that were trying to make decisions for us . . . having to answer questions . . . having to hear some realistic opinions. It got very frustrating . . . I was trying to help my husband to live, help him to survive.
>
> We were so afraid he would have kidney failure or infection would set in.
>
> I was having to fight a battle of survival for he and I both in an unknown place without one person.

Once the immediate danger subsided and survival was assured, the wife's concern shifted to how the farmer would be able to function with his disability.

> I wondered if he was really going to be able to do [farming] because of all the questions people were thinking.
>
> I was afraid for what our future was going to be . . . I just didn't know what was next. That scared me. What was to come.

The farmers' attitudes triggered their spouses' perceptions of hope for recovery. If the farmer was positive and determined to overcome the disability, the spouse was willing to support him to the fullest. Conversely, a farmer's negative attitude impacted the wife's outlook for the future.

> Because of his outlook I could have a good outlook . . . attitude and determination would change your whole thinking. It's according to how [the farmer] is receiving their accident.

> He was just so positive . . . and so I thought 'well he's intending to make it' . . . it just really helped me . . . to see his spirit.

> I thought, 'well he don't seem to care so why should I?'

The wives' responses and commitment to keep their husbands going included physical farm labor, farm management and administration, and personal care assistance for their husbands. The spouse assumed the responsibilitie s normally carried out by their husbands either by physically doing it themselves or securing the appropriate help from others.

> If it was something he'd done, I just did it.

> I came out, picked things up, took care of things, you know . . . those things don't stop just because someone's in the hospital.

> I was trying to farm this farm . . . nobody was making the decisions . . . I've always been the bookkeeper. I know everything that's going on. I just don't know anything about how to do it.

Sheltering

Health care professionals counseled spouses that their husbands would encounter periods of depression and would need all the support possible.

> They were in social psychology, psychiatrists, clergy . . . these people were telling me [things to expect] . . . and him not knowing all this was going on.

> His doctor came by at the hospital and talked to me, pulled me out in the hall, and told me what was going to happen . . . told me he would go through a time that he would be wondering what I was going to think about him.

> He [the doctor] said it [the extent of farmer's depression] would depend on his attitude and the family.

Friends and families conveyed the same message to the wives both directly and indirectly. Any complaints voiced by the women to others would sometimes elicit negative responses.

> And the children, everything I'd say they'd say, 'Well, mom, this and that, and something else.'

Presented with the information about impending depression almost immediately post-injury, the wives assumed the position of sheltering their husbands. This protective behavior pattern displayed itself primarily in the form of suppression of the wife's feelings. Fears, doubts, anger, and personal needs were suppressed because the wives were afraid to risk hurting the disabled farmers' feelings and making them feel worse.

> But I didn't bother him with anything.

> I didn't fuss or anything like that because I thought that will make him more depressed.

> It was a tough thing for him to go through and if I showed weakness, I felt like he was letting me down . . . and I didn't want him to think he was.

It was quickly discovered that the wives verbalized deeper thoughts and emotions when their husbands were not present during the interviews. In interviews conducted with the injured farmer present, the spouse's responses were carefully guarded, evidencing their perception that they must protect the injured farmer from any negative thoughts or situations that could lead to depression.

Sacrifice

Emphasis from health care professionals, family, and the public was placed on the injured farmer and the wives were often excluded. Wives expressed that family and community support for their husbands was overwhelming, but that no one was there for them. "He said it [support] was great. No it wasn't. There wasn't anybody, nobody that I could talk to." Even the outpouring of visits and phone calls recognized as beneficial to the injured person added time demands and increased stress on the wives. With feelings building up inside and no place to vent them, the pressures ultimately found ways of escape through health problems, relationship problems, or a combination thereof.

> If you have to suppress something that is bothering you and you can't discuss that with the person that's affecting you, it does build . . . it would bring anger and resentment and bitterness.

> I wouldn't dare tell him why I was hard to get along with . . . so I just dealt with it . . . I did not say, 'I'm depressed, I'm mad at you.' I never told him why did you do . . . I never said that. Never.

In addition to harboring their feelings inside, the wives were often the targets of their husbands' frustrations. While the public saw the injured farmer at his best and perceived him to have made a remarkable recovery, the women dealt with the other side of the coin. Their statements reflected the added strain and feelings of misunderstanding they felt.

> I can see the ugly side of him. But out in public . . . he's a role model.

> I'm getting all the frustration and . . . everybody else is seeing how well he's doing.

> They put on a good show; you know, everybody says, 'oh you have such a good attitude.' No, no, no, no, no. Everybody else sees that . . . but you [the spouse] catch all the crap.

The conflict between the support the wife felt she must provide her husband and her own needs continually weighed on her. Until a "breaking point" was reached, most wives believed that the farmers' needs had to come first. Even thinking about their own needs led to guilt and anxiety. Their perceptions were that only one person's needs could be met and that it had to be their husbands' needs. Spouses who had reached the breaking point recognized that there must be a balance.

Six of the wives reached this "breaking point," a point where they recognized, either through their own initiative or with the aid of a friend or family member, that their needs were important also and that a balance must be reached. Expressions such as the following described the wives' realization of the need to consider themselves:

> For three years my feelings got stifled . . . I'm just now learning to fight back.

> I didn't have time to think about myself for two years. Then I broke down.

> I finally had to say, listen . . . I can't do that and I just can't do this. And I got to the point where I just don't go ahead and do everything . . . but I just learned to do that the last few years.

Stabilization

The fourth theme in the women's adjustment following their spouses' injury involved a new resolve. Returning to social activities and asserting more independence marked this new self-awareness. Only three of the wives interviewed had reached this point. During the focus group, one

woman who had reached this stabilization point emotionally urged those who had not to stop and take time for themselves. She cautioned that if they did not, a mental breakdown would result.

> If you're not careful, it's going to get you so stressed out . . . Don't let that happen . . . don't let yourself have a nervous breakdown over it. It will age you.

Another dimension of stabilization involves the responsibility for various farm tasks. Generally, once the farmer recovered and adjusted to his disability, he resumed his normal functions, adapting as necessary. In some instances, however, the role reversals occurring at the time of the initial injury remained permanent. Farm wives settled into the routine of performing tasks previously undertaken by their husbands.

While the stabilization phase reflected a new resolve, the process of coping and adjusting did not cease. Each day brought new challenges and obstacles to overcome.

> I'm still under construction. I haven't arrived.

> It was frustrating and sometimes still is.

However, in this stage the wife recognized that her needs also must be met and that adjustment was possible. As one of the wives who had reached this point expressed:

> With every challenge there is the joy of finding a solution . . . sometimes when things are very large we think, 'oh this is unsurpassable.' But it's not true. . . . We all have little hurdles. You just hang in there, and it gets better.

Roles and Needs

Within the framework of these four themes, the wives experienced both positive reinforcement and discouragement in adjusting to their changing situations. Positive reinforcements were identified as encouragement from other amputees, mentoring relationships with other wives of disabled farmers, faith, and coping mechanisms. The presence of another individual who had experienced a similar disability provided the greatest encouragement to the concerned wife. Seeing another amputee whom the wife perceived as functioning "normally" provided evidence that adjustment was possible. This visual assurance was cited over and over as the most beneficial aspect of the recovery process. Seven of the wives interviewed described this encounter as a source of hope and determination.

In previous studies with amputee farmers, Reed (1993, 1996, 1997) found that mentors with a disability were identified as role models that paved the way for physical, occupational, and emotional recovery by providing encouragement and visual evidence of recovery. A mentor relationship with the wife of another disabled farmer also provided a support system to the women. The need to talk with someone who had gone through similar circumstances was reflected in five of the 12 interviews, and within those five interviews, the need was voiced strongly and repeatedly. Carrying the burden alone, the wives began to question whether the care they were providing was sufficient, whether the feelings they had were acceptable, and whether anyone cared about them.

The focus group interview yielded a release of emotions, fears, and questions the spouses had been unable to ventilate to anyone else. As the women talked, the feelings expressed triggered other thoughts and comments with little direction from the researcher. Sharing ideas and supporting one another as stories were articulated evidenced the need for mentor relationships. A camaraderie developed almost instantaneously. The wives who participated in the focus group expressed appreciation for a structured setting where they could freely express what they felt. One wife stated, "It's like you belong to a club. You see that farmer [with an amputation] and his wife and you know what they are going through. Unless you've been through it you don't know."

The source of encouragement provided through mentor relationships was followed closely by the wives' religious faith. Fifty percent of the wives interviewed attributed their faith in God as a major factor in getting through the ordeal. Their personal relationship to God in combination with prayers and support from their church families provided them with the strength needed during the adjustment and recovery process.

> God. That's the only place I had to turn.
>
> Without the Lord we wouldn't have made it . . . you know if you don't have Him to turn to.
>
> We were already Christians. He was in our lives. That's a very vital part of our life that sustained us.
>
> Definitely, I know . . . my spiritual life. And my church was [supportive] and their prayers, special to me.

Spouses discovered various ways of coping after their husband's injury. Some countered by getting away with a friend, some voiced their complaints to God and anyone else willing to listen, and others withdrew into themselves to avoid conflict with those who disagreed with how things were being handled. Humor also was cited as a means of coping.

> You have to laugh. If you don't laugh, some days you'll be just crying your eyes out.

Along with the positive reinforcement, the wives were confronted with frustrations and discouragement during the adjustment process. The two primary factors that discouraged the wives were increased roles and responsibilities placed upon them and the conflicts encountered from not knowing when to offer help to the disabled farmer. Following a disabling injury, the roles of therapist, nurse, and information seeker are immediately thrust upon the spouse.

> I had to become a doctor, had to become a nurse, I had to become very educated in what was going on . . . I had to stay alert.

> The doctor said, 'Let his wife give the IV and do the exercise.' All my responsibilities picked up a whole lot.

> If there was anything to find out, I had to get the information . . . I'd have to think of all the questions to ask the doctor.

In addition, the women had to assume many, if not all, of the farming responsibilities during their husbands' recovery, while continuing to perform their roles of wife, mother, and agricultural partner. Although some of the new roles were temporary until the farmer was able to return to work, some became permanent responsibilities, and certain roles were reversed. Such increased responsibilities disrupted the wife's normal routines and placed additional time demands on her. The expanded workload and lack of time for themselves frequently affected the health of the spouses.

> I could't sleep. My mind kept always going . . . tomorrow we've got to do all the paperwork, tomorrow I've got to make sure that he has everything he needs.

> I would be so utterly exhausted by the time the days was over because I had to do for him.

Compounding the wives' problems were the conflicts encountered from not knowing when to extend a helping hand to their husbands. The farmers' needs varied from day to day, function to function, and mood to mood. The wives found themselves in constant turmoil between the desire to help and shelter their husbands from situations that could lead to depression and their recognition of their husbands' need to become independent. If help was offered, the farmers sometimes responded in anger. At other times, if help was not offered, even under the same circumstances, the farmers questioned why their spouses did not offer assistance. Knowing where to draw the line was a constant dilemma.

> Because of his frustration . . . there was nothing I could do that was right . . . If I did it the way he told me to it was still wrong.

The stress of trying to simultaneously fulfill all responsibilities and meet their husbands' needs eventually played havoc on the spouses' physical and mental health. The women experienced physical exhaustion, depression, and mental breakdowns.

> By the time I'd get started, I would be tired. And then I stayed on my feet all day long . . . it was really physically too much for me.

> I had enough to do before this happened and this just put more, more strain . . . and see, I'm not supposed to have stress or anything because of my heart . . . he'll live longer than me.

> I have gone through many grieving processes . . . something in your life is gone. There is a grieving process, there is withdrawal.

> There were [times] I'd think 'golly, how am I going to do another day?'

> Whenever we got all settled down and he's doing fine . . . then it [depression] hits me.

> I didn't have time to think about myself for two years. Then I broke down.

One farm wife summed the experience best by her statement, "I may not deal with it on a physical basis, but we live with it every day. Spouses and children and whoever lives with someone who has a [disability]. They live with it just as well as the person who is missing an arm or a leg. I deal with it on a daily basis."

CONCLUSIONS AND RECOMMENDATIONS

Following their husbands' permanently disabling injury, farm wives must adjust not only to the loss encountered directly by the injury but also to increased responsibilities, time demands, and role reversals. They are called on immediately post injury to simultaneously provide caregiving skills, make family adjustments, and oversee the administration of the farm. All the while, the wives feel they must remain positive to minimize their husbands' depression. Increased time and responsibility demands, along with the suppression of feelings, placed a heavy toll on the wives' health. As a result, they became exhausted both physically and emotionally. These findings are similar to Rosenburg's (1998) work with spouses of persons with mild head injury. The movement of the wives through the recovery process is a linear process. The first phase,

survival, is thrust upon them without warning. It is a reactionary impulse to fight for the survival of a loved one. The rapid propulsion to sheltering indicates a shift from the physical support to the emotional support of the injured person. Members of farm families know that farm work is time and weather sensitive. Most injuries occur during times of peak work; therefore, the wife must immediately assume farm management responsibilities and even physical farm work, if there is no one else who can step in to fill these roles. While community support was appreciated, the women also felt it was their responsibility to maintain the business. To farmers, health is the ability to work (Weinert & Long, 1991). The wives served as buffers between their husbands and negative news or negative thoughts about their farm operations and ability to return to work.

The physical work and emotional strain led to exhaustion of the wives' own inner resources as reflected by the sacrifice of their health. Some participants in this study were able to withstand many months, even years, of strain before they reached complete exhaustion, but all participants experienced it. It was during this period that the women's health was most vulnerable. This difficult time decreased if the wife was linked with a mentor and community groups and provided with supportive materials. Encouragement frequently was found through personal faith, but the spouse may feel isolated and ashamed of her feelings of inadequacy. These findings are congruent with the rural culture and belief system (Bushy, 2000).

The needs voiced most strongly by the wives in this study were for understanding and support. One venue to meet these needs might be a mentor relationship with someone who has gone through similar circumstances. While seeing another disabled farmer functioning "normally" provided assurance that recovery was possible for the disabled farmer, the spouse also needed assurance that she could adjust to the changes brought about by the injury. Talking with another spouse of a disabled farmer was perceived as an opportunity to release fears, doubts, and feelings without being judged or criticized.

Nurses are particularly suited to assist the spouse during the initial recovery period. Acknowledging the pressures placed upon the spouse, directing the family to supportive programs, and identifying special needs of the family unit should all be included in the initial care plan of the injured farmer.

Unlike most other occupations, farm families must realign work roles quickly when a family member is disabled. Time-sensitive crops must be tended, and bills must be paid to maintain a physical home, which is most often located on the farm. Spouses and children must immediately assume work roles for which they may be untrained and physically unaccustomed. Health care professionals still underutilize new

programs specifically planned for caregivers of farmers with disabilities. AgrAbility, a service project of the United States' Department of Agriculture, sponsors a peer network of farmers with disabilities that was recently expanded to include their spouses (Barn Builders, 1999). Peer network volunteers may be contacted by telephone or mail. Some volunteers even make farm visits. AgrAbility programs offer opportunities for direct interaction through conferences and workshops. Rural nurses can work with other community organizations such as the Cooperative State Research, Education, and Extension Services to deliver caregiver educational programs and direct spouses to appropriate health care if needed (Delks & Fields, 1997; Delks, Field, Sutherlin, & Reed, 1999). These types of interventions can assist the spouse in coping with her (or his) own adjustment after the injury. Persons who do not have the advantage of a strong and stable marriage prior to the disabling event may feel adjustment needs more acutely. The participants in this study indicated that their excellent relationships with spouses helped them withstand the challenges they faced. The researchers could not locate persons whose marriages ended after these types of catastrophic events. Data from those persons may be very different from data collected in this study. In essence, this study reflects a "healthy worker effect;" that is, spouse "survivors" were interviewed. Interviews with spouses whose marriages ended after the disabling event should be conducted. All the spouses in this study were female. The needs expressed by male spouses of injured farmers may be different.

Mental health nurses should be alert to the mental strains present after a serious injury to a spouse. Support of the spouse should be part of the nursing care plan. Focus groups appear to be a beneficial intervention that is cost-effective as well. Nurses should be equipped with knowledge about local resources that are available so that appropriate referrals can be made. As voiced by one family member of a disabled farmer, "It [the injury] didn't just happen to [the disabled farmer]; it happened to all of us." This study has illuminated what happens "behind the scenes" as spouses cope with disabling injuries of their husbands.

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