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The Relationship of Coping Behaviors, Resurrection Beliefs and Hopelessness Scores Among Bereaved Spouses of Hospice Patients

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by

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Approval

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Resurrection Beliefs and Hopelessness Scores
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Abstract

Hope is essential to effectively face the trials of life. One of life's most stressful trials is coping with the death of a loved one. Understanding coping differences may promote counseling interventions to benefit individuals who feel hopeless.

The Beck Hopelessness Scale (Beck, 1974) and the Ways Of Coping Questionnaire-Revised (WOCQ-R) (Folkman & Lazarus, 1988), were used in a survey of 97 bereaved spouses of hospice patients to answer four questions: (a) Does a relationship exist between coping behaviors and levels of hopelessness? (b) Is there a relationship between resurrection beliefs and hopelessness? (c) Are differences in resurrection beliefs related to differences in coping behaviors? and (d) Are differences in spontaneously reported

coping behaviors, spiritual or non-spiritual, related to differences in hopelessness?

Using the eight factors associated with the WOCQ-R and Spiritual Coping responses, a Pearson correlation revealed "Positive Reappraisal" had the strongest relationship with hopelessness ($r = -.278$ $p < .01$), followed by "Planful Problem Solving" ($r = -.274$ $p < .05$).

A discriminant analysis revealed that individuals who strongly believe in the resurrection used different coping behaviors than individuals who did not hold such beliefs. Coping behaviors associated with Resurrection Belief were: Seeking Social Support, Accepting Responsibility, Spiritual Coping, and less uses of Escape-Avoidance.

No significant difference was found in hopelessness scores among individuals who strongly believe in the resurrection and those who did not. Neither was there a significant difference in hopelessness scores among participants who spontaneously reported using Spiritual Coping compared with those who spontaneously reported Non-Spiritual Coping. These non-significant findings may have occurred because of lack of participants who were

hopeless and few participants who expressed disbelief in the resurrection. Furthermore Spiritual Coping may have been underestimated since Seeking Social Support, keeping busy, etc. may involve spiritual activities yet were not coded as spiritual.

Counseling implications to reduce hopelessness include reappraisal of stressors in light of personal growth and the encouragement of Planful Problem Solving. Recommendations for future research included exploration of coping behaviors and after-life beliefs among individuals experiencing higher levels of hopelessness, and investigating longitudinal changes in the coping process.

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CHAPTER 1

INTRODUCTION

Hope has many dimensions. It provides motivation and empowerment to cope with the severest of stressors. Hope expects a meaningful future and believes that goals are attainable. Hope is considered essential if we are to face the trials of life effectively. There are many ways of describing hope, and there are many individual differences in the experience of hope or its converse hopelessness. Why does one person feel hopeful and another feel hopeless when faced with similar stressors? Perhaps differences in hope are determined by different foundations of hope. In other words, one's hope is only as secure as what it is anchored to. In some cases being hopeful or hopeless

may result from the individual's appraisal of the effectiveness of his or her perceived coping options. It is likely that multiple factors contribute to feelings of hopefulness or hopelessness. This research explored the relationship of coping behaviors, resurrection beliefs, and hopelessness among bereaved spouses.

One of the most stressful trials of life is coping with the death of a loved one. No amount of wishing will return life to the person who has died. We are powerless to change the facts of death. Therefore the question becomes one of how to cope with the multiple losses associated with the death of a loved one. Examples of multiple losses include: loss of a unique relationship, loss of companionship, loss of future dreams involving the deceased, loss of role identity as related to the deceased, and possibly loss of opportunity to resolve emotional wounds. Such losses touch the very core of the bereaved. Considering that one cannot undo death, and the multiple losses associated with death, one can understand why some bereaved individuals experience feelings of hopelessness. The majority of people cope with bereavement without becoming hopeless or experiencing a

major clinical depression. However, some experience debilitating and sometimes life threatening hopelessness following the death of a loved one. The current research was conducted to explore whether coping behaviors and resurrection beliefs are related to hopelessness. It was thought that an understanding in those areas could contribute to the development of tools that would enhance the interventions of bereavement counselors.

In this chapter key concepts relevant to bereavement, coping, and hope are introduced. Included in the chapter are descriptions of the stressful nature of bereavement and examples of the potential effects of bereavement stress. The purpose of the current research is stated, followed by a review of relevant literature. Topics of the literature review include previous studies that indicated a need for research on coping with bereavement and studies indicating a need for research on spiritual coping behaviors. Examples of spiritual coping in previous studies are also presented. Attention then turns to Folkman and Lazarus' definition of coping, select definitions of hope, and various measures of hope and hopelessness, including the Beck Hopelessness Scale. The importance

of hope in coping is reviewed, and a Biblical perspective of hopeless grieving and Spiritual Coping is provided. Following the literature review, a brief introduction to hospice and its holistic philosophy of treatment is given. The chapter is concluded with a brief summary of the chapter, followed by a presentation of hypotheses investigated by the present research.

Problems Associated with Bereavement Stress

Throughout history, caring for dying persons has been a heavy responsibility for the living. An investigation of the transition from caregiver to bereavement, and the relationship of care-related strain and adjustment to death, revealed that some family members who provided care for a chronically ill or disabled aged relative experienced deterioration in the following areas: health, general well-being, family relationships, social activities, and finances (Bass & Bowman, 1990). Such research supports the perspective that terminal illness strongly effects the dying person's family, and that the emotional burden of watching the slow death of a loved one can be

overwhelming (Paulay, 1986). Herth (1990) described conjugal bereavement as an extremely stressful life experience that creates a significant adaptive challenge for the surviving spouse. She argued that grief resolution places enormous demands on coping skills.

Further evidence concerning the severity of stress associated with the death of a spouse can be attained from two well known sources. The Social Readjustment Rating Scale rates the death of one's spouse as one of life's most stressful experiences (Holmes & Rahe, 1967). Likewise, the Severity of Psychological Stressors Scale for Adults classifies the death of a spouse as an "extreme stressor" (Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised, American Psychiatric Association, 1987).

It is not uncommon for individuals to experience a wish to die or to have suicidal thoughts following the death of a loved one (Tate, 1985). The belief that one cannot cope with the overwhelming feelings often associated with grieving may result in a disabling sense of hopelessness. The potential for hopelessness is a serious problem associated with bereavement that must be addressed.

Minkoff, Bergman, Beck and Beck (1973) found that the seriousness of suicidal intent is more highly correlated with hopelessness than with depression. Therefore, understanding a bereaved spouse's level of hopelessness is crucial in assessing suicidal risk. A grief stricken spouse who feels hopeless may attempt or complete a suicide when appropriate intervention is lacking. It stands to reason that in order to develop effective interventions one must understand the factors that promote hope or contribute to hopelessness. In particular, one must understand which beliefs or behaviors contribute to hopefulness when an individual is faced with the loss of a spouse.

Statement of Purpose

In consideration of the numerous risks that assail the grieving spouse, and the apparent importance of hope, an investigation of coping behaviors and beliefs which may contribute to a sense of hope or correlate with hopelessness seemed warranted. The purpose of this research was to answer four questions relevant to coping behaviors and hopelessness among bereaved spouses of hospice patients. (a) Does a relationship

exist between coping behaviors and levels of hopelessness among bereaved spouses of hospice patients? (b) Is there a relationship of resurrection beliefs and levels of hopelessness among bereaved spouses of hospice patients? (c) Do participants who report a strong belief in the resurrection use different coping behaviors than participants who do not hold such beliefs? and (d) Will participants who spontaneously report Spiritual Coping as their primary way of coping with bereavement differ in level of hopelessness when compared with individuals who spontaneously report Non-Spiritual Coping?

Literature Review

Someone once said, "It is better to have loved and lost, than to never have loved at all." The desire to love and be loved seems to be an inextricable aspect of our identity as human beings. It seems inevitable that our deep emotional commitments and our bonds of attachment will lead to a sense of great personal loss when relationships of love are severed by death. It is probable that humans are the only life form that knows well in advance that death will occur. Yet such

knowledge of the inevitable does little to offset the emotional pain experience by the bereaved. Grief is the price one pays for being able to love.

This literature review presents material in eight areas relevant to this investigation of coping with bereavement: (a) the need for research on coping with bereavement, (b) the need for research on spiritual coping, (c) spiritual coping behaviors, (d) Folkman and Lazarus' definition of coping, (e) select definitions of hope, (f) an introduction to the Beck Hopelessness Scale, (g) the importance of hope in coping, and (h) a Biblical perspective on hopeless grieving.

The Need For Research On Coping with Bereavement

One can speculate that grief has always followed death. Cultural anthropologists observe that every group of people have traditions of death and mourning. In today's world people continue to experience grief in ways reflecting cultural norms. It is likely that the nature of the lost relationship, spiritual beliefs, personality factors, and individual coping preferences also influence one's experience of bereavement.

In the social culture of the United States the intense and personal feelings associated with mourning

are generally considered private. Therefore conducting research which asks people to express such intense and personal feelings is difficult. Empirical investigation of bereavement has been an unspoken taboo. However, in recent years a variety of authors have begun to explore certain domains relevant to death, dying and bereavement. Areas where research is lacking have been identified and many researchers have concluded that there remains a need for additional research on bereavement. A select overview of such research is presented in this section to demonstrate the need for research which specifically investigates how people cope with bereavement stress.

The work of Kubler-Ross (1969) gave much impetus to research on the psychological aspects of death and dying. She is generally considered the founder of the hospice movement in the United States. Her book, On Death and Dying, however, was not specifically focused on bereavement, and in fact only a few pages actually addressed bereavement. Her work did promote public awareness regarding the value of understanding more about the process of dying and how people cope with pending death. She demonstrated that such understanding actually promotes human dignity when

respectfully attained. In this way Kubler-Ross opened doors for research on bereavement.

Neugarten's (1970) early theoretical work that investigated the impact of spousal death suggested that events which are "on time" in the life cycle may have less severe impact than events which occur in an untimely fashion (e.g. death of a spouse during childbearing years). She found age was more important than mode of death to explain the intensity of grief reactions, with younger widows reporting more severe distress. In contrast, Sanders (1980-81) found that 47% of her group of older widows were making poor adjustment to loss while this was true only 29% of her younger sample. Symptoms intensified over time for the older widows whereas younger widows were more hopeful and less socially isolated 18 months later. These apparently conflicting findings warrant further investigation because small samples were used in both studies and neither was a controlled longitudinal study.

Survivor's age, timeliness of death, and cause of death have uncertain effects with respect to how one will cope with grief. People do not choose an age to be widowed, or the cause of their spouse's death.

People do however make choices, or neglect choices, concerning how they will cope with the death of their spouse. How a person copes with the death of a loved one involves many personal choices and coping options. An exploration of differences in coping behaviors may provide answers that account for the apparently conflicting research on adjusting to bereavement.

Campbell, (1983) reported that in general the research on coping has been inadequate theoretically. Campbell reported four theoretical inadequacies:

> First, the early coping research had a defense mechanism bias (e.g. Haan, 1977; Vaillant, 1971). This concept of coping tends to view coping as a defense against the disorganization of the ego. Thus, active attempts to problem-solve are subordinated to tension-reduction attempts to preserve the ego (Folkman & Lazarus, 1980). Second, research of the 1960s and 1970s tended to focus on coping personality traits to the exclusion of recognizing that people cope differently in different situations. This view is seen in the Repression-Sensitization Scale by Byrne (1964). Third, some research only examined cognitive styles such as "active" or "passive" in

specific situations and labeled these as coping (e.g. Shanan, De-Nour, & Garty, 1976). Such approaches are not based on a general coping theory and therefore lack theoretical framework. Fourth, the research on coping skills intervention is inadequate because of its general rather than specific nature. Some cognitive-behavioral therapists suggest a generalized approach to teaching coping skills, rather than emphasizing an individual, situational-specific approach (e.g. Mahoney, 1977).

Campbell (1983) also identified practical inadequacies of research on coping with chronic illness. He observed that many of the approaches to teaching people coping skills are inadequate because they discourage people from using presumably "maladaptive" coping skills such as denial or passivity. Research has shown that denial can be an effective life-saving coping skill (Gentry, Foster, & Harvey, 1972). One may ask if there might be similar surprises relevant to adaptive and maladaptive coping with bereavement.

Worden (1982) presented research on bereavement which among other things included: normal grief reactions, pathological grieving, and four tasks of

mourning. Such topics raise questions and theories about why one's grief is normal and why another's grief is pathological. Worden's discussion of how grief goes wrong included four types of grief reactions: chronic, delayed, exaggerated, and masked. Although those precise grief reactions are not a focus of this study, it raises the question of which coping behaviors would be associated with each reaction type.

In the current study coping behaviors were investigated to determine if such behaviors were related to differences in feelings of hopelessness. An underlying assumption of the current study was that some coping behaviors would promote feelings of hope and others would promote feelings of hopelessness. An understanding of complicated grief reactions may provide epidemiological insight concerning coping behaviors that are related to feelings of hopelessness. It is for that reason the 12 "clues" Lazare (1979) provided as evidence of complicated grief have been paraphrased:

> (a) Inability to speak of the deceased without experiencing intense and fresh grief. (b) Relatively minor events trigger intense grief reactions. (c) Themes of loss come up in clinical

interviews. (d) The bereaved is unwilling to move material possessions belonging to the deceased. (e) Development of physical symptoms like those experienced by the deceased. (f) Radical changes in lifestyle. (g) A long history of subclinical depression. (h) A compulsion to imitate the dead person. (i) Self-destructive impulses. (j) Unaccountable sadness occurring at certain times each year. (k) Phobia about illness or death. (l) Avoidance of death-related rituals or activities.

Although such clues are useful in identifying complicated grief, there remains a need to explore how the coping behaviors of "pathological mourners" differ from the coping behaviors of individuals who experience "normal grief reactions." If given an opportunity to report coping behaviors, will "pathological mourners" report coping behaviors reflecting elements of Lazare's 12 clues? Pathological mourning was not a variable of the current study per se and there were no tests to identify pathological mourning. However, the current study included measures for a expressing a variety of coping behaviors and for identifying feelings of hopelessness. In consideration of coping behaviors and

Lazare's 12 clues it was anticipated that bereaved spouses who report coping behaviors reflecting a refusal accept the death of the spouse (extreme efforts to maintain the past, imitation of the dead person) would also report more hopelessness than participants who select coping behaviors indicating an acceptance of the reality of the death of the spouse. This is consistent with Worden's (1982) first and third tasks of mourning: to accept the reality of the loss and to adjust to an environment in which the deceased is missing. The current literature suggests a need to investigate if bereaved spouses who cope by avoiding people, places, and events which might evoke feelings of grief are more hopeless than "non-avoiders". An investigation of that nature is also supported by Worden's (1982) second task of mourning: to experience the pain of grief. The need to explore avoidant coping is also supported by the finding that avoidant coping and the non-use of approach coping, in response to stressful life events, predicted psychological disturbance 4 months later (Smith, Patterson, & Grant, 1990).

The topic of coping with the impact of bereavement remains relatively new to mental health. Walsh and

McGoldrick (1991) observed that "By and large, the mental health field had failed to appreciate the impact of loss on the family as an interactional system" (p. 3). Therefore their contributors addressed a variety of topics relevant to family bereavement. Thus, research is available on various aspects of bereavement; however additional research concerning what people actually do to cope with bereavement is still needed. "There is a paucity of information on bereavement reactions in persons over the age of 60" (Gallagher, 1987 p.59). Gallagher (1987) reviewed a number of therapeutic interventions that hold promise for the treatment of both normal and abnormal grief reactions of the elderly and concluded, "Much still remains to be learned about the characteristics of those who cope well versus those who will react with morbidity or mortality, and many studies will need to be done to evaluate the effectiveness of the various interventions and programs discussed" (p. 62).

There is a considerable amount of research concerning the stressful effects associated with trauma, chronic illness and terminal illness. A substantial amount of research provides evidence that bereavement stress may impair psychological well-being,

physical health, and social and family relationships (Bass & Bowman, 1990). Research concerning the construct of hope generally focuses on people who are recovering from trauma, or on individuals who have a chronic or terminal illness. However, the construct of hope or its converse, hopelessness, among the bereaved is seldom empirically investigated. And, research exploring beliefs or coping behaviors which may contribute to grief resolution is sparse. A critical need to investigate the intervening and influential factors that shape and modify grief resolution has been identified (Dimond, 1981; Demi & Miles, 1986).

Research which investigated personal variables, such as age, length of marriage, financial status, education, and living arrangements, have not found any clear pattern for delineating the influence of those variables on grief resolution (Hauser, 1983; Windholz, Marmar, & Horowitz, 1985). While much research has focused on broad categories or types of coping behaviors (action oriented, instrumental, palliative, intrapsychic), few researchers have examined specific, self-reported coping behaviors of older persons or attempted to identify those strategies that are particularly effective in maintaining well-being and

facilitating adjustment (Koenig, George, & Siegler, 1988).

Prior to 1990 there was no reported research that addressed the relationship of hope to grief resolution (Herth, 1990). Wolfelt (1987) and Smith (1983) suggested that hope provides an incentive for constructive coping with loss. Herth (1990) found that hope accounted for 79% of the variance in grief resolution in elderly widows and widowers.

This current study investigated self-reported ways of coping with bereavement and explored variables such as coping behaviors and resurrection beliefs in an effort to understand if a relationship existed among such variables with respect to hopelessness. According to Lazarus and Folkman (1984), belief determines one's reality by shaping the definition of what is and by determining what meaning is involved. General beliefs include beliefs about personal control, situational control, and existential beliefs. "Existential beliefs include beliefs in God, fate, or some natural order in the universe, are general beliefs that enable people to create meaning out of life, even out of damaging experiences, and to maintain hope" (p.77). Identifying beliefs and behaviors related to having hope or being

hopeless can contribute to our understanding of the grieving process and may enhance the effectiveness of bereavement counseling.

The Need For Research On Spiritual Coping

Many articles in nursing, medicine and psychiatry have examined the role of hope in coping with illness and suffering (Brown, 1985; Dufault & Martocchio, 1985; Herth, 1989; Nowotny, 1989). However, there is little consideration of the effects that after-life beliefs have on the establishment or maintenance of hope among the bereaved. Furthermore, there is little research concerning how after-life beliefs may influence coping behaviors. Spiritual beliefs and behaviors are generally left out of the psychiatric literature. Sherrill and Larson (1988) propose that one possible explanation is the discrepancy of religious beliefs among patients and caregivers. They cited a survey of the American Psychiatric Association membership by the American Psychiatric Association Task Force (1975), which indicated that only 43% of the American Psychiatric Association membership stated a belief in God, compared with 95% of the general public as documented in the Gallup polls 1935-1985 (Gallup,

1985). A subsequent study of Religion in America, conducted by The Princeton Religion Research Center with George Gallup as executive Director, found that 94% of Americans believe in God. "The vast majority of Americans believe in God or a universal spirit, the proportion having remained remarkably constant during nearly four decades of scientific polling" (Bezilla, 1993, p.20). Very few people view God either as an abstract idea (5%) or as an impersonal creator (2%). Far more view God as the heavenly father of the Bible who can be reached by prayers (84%). Only 4% would not venture an opinion concerning the nature of God's being. Those who did not believe in God or a universal spirit comprised 5% of the sample. History indicates that the majority of American's believe in God, yet there is little research on how belief in God influences coping. Campbell (1983) observed,

> There is a dearth of research on the relationship between spirituality and coping. It seems that the only time spirituality and religiosity are mentioned in the research literature is in regard to psychopathology. Thus, the constructive use of one's spiritual beliefs are rarely investigated,

> and there appears to be a bias against it by psychological researchers (p. 58-59).

There are exceptions to this general lack of research on spiritual beliefs and coping. A few examples are presented in the following section.

Spiritual Coping Behaviors

The Princeton Religious Center's study on Religion in America (Bezilla, 1993) asked, "How important would you say religion is in your life?" Among adults 50 and older, 70% very important, 20% fairly important, and 9% not very important (N = 3,119, p.55). Widowed participants reported: 78% very important, 17% fairly important, 5% not very important (N=648, p. 55). Such findings suggest that widowed individuals value religion somewhat more than the older sample reported.

When individuals are given an opportunity to freely report coping behaviors relevant to a variety of stressors, research has found that spiritual behaviors are often reported as the preferred coping strategy. For example, Baines (1984) identified several mechanisms used by family care givers to manage stress and found prayer to be the primary method of coping. Saudia, Kinney, Brown, and Young-Ward (1991), found

that there were no significant differences of perceived helpfulness of prayer among individuals with an external locus of control compared with individuals who had an internal locus of control. Prayer is perceived by each locus orientation as a helpful direct-action coping mechanism. Such findings merit the attention of mental health personnel. Further research exploring the effects of prayer on patients' ability to cope with stressful situations was recommended (Saudia Kinney, Brown, and Young-Ward, 1991).

The finding that spiritual coping behaviors were highly valued was further supported by Koenig, George, and Siegler (1988). They interviewed 100 persons age 55-80 and asked questions regarding the worst and best events or times they had experienced in (a) their whole lives, (b) the past 10 years, and (c) at the present time. A total of 556 emotion-regulating coping strategies were spontaneously offered in response to 289 reported stressful events. Specific coping behaviors which were reported to be especially useful in coping with stressful life changes were identified. The prevalence and characteristic expression of religious coping behaviors were investigated. Religious coping strategies were the most frequently

mentioned coping strategies used by older adults (17%). The next three most popular coping strategies were: "Kept busy" (15.1%), followed by "Accepted it" (11.3%), and "Support from family and friends" (11.1%). Twenty-one other responses were less frequently mentioned (6.1% - .5%) and will not be individually listed.

Koenig, George, and Siegler (1988), report that almost half (45%) of the participants mentioned religious attitudes or actions as important for dealing with at least one of the three stressful events; 17% mentioned religious behaviors for two of the three events; and 9% reported religious coping for all three stressful events. Both private and social religious behaviors were prevalent coping behaviors of older adults and were used to cope with 26% of all stressful situations.

The rank order of religious coping behaviors spontaneously reported by 45 older adults is reported in Table 1. Almost three-quarters (74.2%) of religious coping behaviors reported were accounted for by the top three coping behaviors: Placing trust and faith in God (30.9%), Praying (26.8%), and Obtaining help and strength from God to cope with the situation (16.5%).

Table 1

Spontaneously Reported Religious Coping Behaviors Of Older Adults

Rank order	Frequency of mention	
	n	%
Trust and faith in God	30	30.9
Prayer	26	26.8
Help and strength from God	16	16.5
Church friends	7	7.2
Church activity	6	6.2
Minister's help	5	5.2
Read the Bible	4	4.1
Knowing it was the Lord's will	2	2.1
Lived a Christian life	1	1.0
Totals	97	100.0

Note. N = 45. The data in table 1 is from Koenig, George, and Siegler, 1988.

Table 1 also shows that the remaining 25.8% of spontaneously reported religious coping behaviors were: Church friends (7.2%), Church activity (6.2%),

Minister's help (5.2%), Read the Bible (4.1%), Knowing it was the Lord's will (2.1%), and Lived a Christian life (1.0%).

Koenig, Moberg, and Kvale (1988) found that, among adults age 75 and over, religious activities and attitudes explained more of the variance in well-being than any other variable except for health. Koenig, George, and Siegler (1988) concluded that religious attitudes and activities are the predominant coping behaviors reported by older adults. This has been true regardless of the research method employed. Whether direct questions concerning religious coping are asked, checklists of coping responses offered, or spontaneous coping behaviors elicited, the responses have been consistent. This current research provided an opportunity for another population, under different circumstances, to spontaneously report coping behaviors prior to responding to a checklist of coping behaviors. An important aspect of the current research was to investigate if religious beliefs and behaviors are predominant methods of coping in yet another population, under different circumstances, when using different measures.

Koenig, Cohen, Blazer, Pieper, Meador, Shelp, Goli, and DiPasquale (1992) asked hospitalized medically ill men an open-ended question about how they coped. Twenty percent (N=167) of the participants spontaneously replied that religion was a primary factor (24% of those 70 years and over). Religion in this sense typically involved having trust or faith in God, praying, reading the Bible or other religious literature, listening to or watching religious programs, participating in church services or other related activity, and receiving emotional support from church members or a pastor. Twenty-one percent of the participants rated religion as "the most important thing that keeps me going."

Soeken and Carson (1987) present the importance of adopting a perspective where people are viewed as a balance of mind, body, and spirit. They state: "These parts cannot be separated, but rather function as an integrated unit with the whole person more than the sum of the parts. Each dimension - mind, body, spirit - affects and is affected by the others" (p. 603). Consequently, responding to the needs of a person requires an understanding and care for the total person, including the spirit (this perspective is

consistent with the hospice philosophy presented later in this chapter).

In a study that used a phenomenological approach to describe the components of courage among chronically ill adolescents, spiritual factors emerged as affecting coping (Haase, 1987). Nine adolescents were asked to describe a situation during the course of the illness in which they had been courageous. Sources of hope, such as prayer by self and others, and faith in God, were transcendent themes that emerged. Participants reported that the opportunity to express their faith helped them to resolve the situations they described.

Sodestrom and Martinson (1987) reported that 22% of their patients with cancer found their meaning and purpose in life through their belief in and relationship with God. Patients reported their most frequently used coping strategies were personal prayer and asking others to pray for them. The next highest category of activity included use of religious television, radio, music and objects (such as plaques, rosaries, and wall hangings), reading religious books and/or the Bible. Patients read the Bible an average of 6 hours per week.

Herth (1989) investigated the relationship between religious convictions and level of hope and coping responses among patients with cancer. A significant positive relationship ($r = 0.80$, $p = 0.001$) was found between level of hope indicated by Herth Hope Scale scores and level of coping response indicated by Jalowiec Coping Scale scores, using the Pearson r correlation coefficient. The co-variance between hope and coping response level was 64%. Participants who indicated a strong religious faith had significantly higher mean scores on the Herth Hope Scale and the Jalowiec Coping Scale than the mean score of the other four groups (Weak, Unsure, Lost, or Without Faith).

Thus far, a variety of reasons supporting the need for research on coping with bereavement have been presented. In addition evidence was provided which indicated that hope played a vital role in coping with stressful situations. In particular, religious coping ranked high as an important way of coping with stressful life events. At this time the focus of this chapter shifts to understanding the concept and measurement of coping as developed by Folkman and Lazarus (1980).

Folkman and Lazarus' Definition of Coping

In recent years conviction has grown that it is how individuals cope with stress, not stress per se, that influences psychological well-being, social functioning, and somatic health. Despite increased interest in coping, empirical research has been limited until recently by lack of suitable assessment techniques. The conceptual background of coping according to Folkman and Lazarus (1980), is concisely summarized in the Manual for the Ways of Coping Questionnaire (research edition, 1988). Folkman and Lazarus define coping as the cognitive and behavioral efforts to manage specific external and/or internal demands appraised as taxing or exceeding the resources of the individual. This definition has four key features: (a) it is process-oriented, (b) it speaks of management rather than mastery, (c) it makes no a priori judgement about the quality of coping processes, and (d) it implies a stress-based distinction between coping and automatic adaptive behaviors.

Gass and Chang (1989) report:

> The model of stress, appraisal, and coping developed by Lazarus and Folkman (1984) is a useful theoretical framework for research and

> theory development that is applicable to bereavement (Lazarus, 1966), but has seldom been systematically applied to health functioning and coping following bereavement. (page 32)

A brief description of the eight coping scales contained in the Ways of Coping Questionnaire-Revised, is presented in Table 2. The coping scales are presented here to build an understanding of how the WOCQ-R coping scales were define by Folkman and Lazarus (1988). The eight coping scales were integrated with other research presented in the literature review to establish the rationale for hypotheses investigated by the current research. (A further description of the WOCQ-R has been included in chapter 2.)

Table 2

Description of Folkman & Lazarus' Eight Coping Scales

Descriptions Of Coping Factors
Confrontive Coping Describes aggressive efforts to alter the situation and suggests some degree of hostility and risk taking
Distancing Describes cognitive efforts to detach oneself and to minimize the significance of the situation
Self-Controlling Describes efforts to regulate one's feelings and actions
Seeking Social Support Describes efforts to seek informational support, tangible support, and emotional support

(table continues)

Table 2 -- Continued

Descriptions Of Coping Factors
Accepting Responsibility Acknowledges one's own role in the problem with a concomitant theme of trying to put things right
Escape-Avoidance Describes wishful thinking and behavioral efforts to escape or avoid the problem. Items on this scale contrast with those on the Distancing scale, which suggest detachment
Planful Problem Solving Describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem
Positive Reappraisal Describes efforts to create positive meaning by focusing on personal growth. It also has a religious dimension.

Note: From The WOCQ-R Manual (Folkman & Lazarus 1988).

Defining Hope

There are numerous definitions of hope described in the literature. Select examples are reviewed here to foster an appreciation for the variety of facets associated with hope. This section concludes by presenting the definition of hope used for the purposes of this research.

Hope is seen as providing people with a "will to live and recover." It is a construct that provides future-orientation (Carson, Soeken, & Grimm, 1988). Hope has been described as the most potent of all medicines, one that can heal and rejuvenate. It is referenced in the future, grounded in the past, and experienced in the present. It involves the expectation that life will be a little more comfortable, a little more meaningful tomorrow. Hope is essential in any struggle with a major disability or catastrophic illness (Mader, 1988).

Hope can be defined as the state of mind which results from the outcome of ego strength, perceived human family support, religion, and economic assets (Obayuwana, Collins, Carter, Rao, Mathura, & Wilson, 1982).

Farran (1985) conceptualized hope as having the following four central attributes: (a) presupposing suffering, trial, or captivity; (b) involving transcendence, freedom, and faith; (c) a rational thought process; and (d) an interactive process.

Miller and Powers (1988) defined hope as a state of being, characterized by an anticipation of a continued good state, an improved state, or a release from a perceived entrapment. The anticipation may or may not be founded on concrete, "real world" evidence. Hope is an anticipation of a future which is good, based on relationships with others, a sense of personal competence, coping ability, psychological well being, purpose and meaning in life, and a sense of "the possible."

Nowotny (1989) identified the following six dimensions of hope which became the subscales for Nowotny's Hope Scale: confidence in outcome, possibility of a future, relates to others, spiritual beliefs, comes from within, and active involvement.

Herth (1989) defined hope as an energized mental state characterized by an action-oriented, positive expectation that goals and/or needs for self and future

are attainable, and that the present state or situation is temporary.

> For Kuenning (1987),
>
> Hope is the basic ingredient of human strength, without which our souls cannot survive. Until the day we die, we need hope- our final hope of heaven and a continuing relationship with those who have gone before us and with God. Without hope we despair. (p. 203)

For purposes of this study, hope is defined as a state of being characterized by confident belief that a valued goal is attainable now or in the future. Hopelessness can be understood to be the absence of hope, or the opposite of hope. In turn, hope will be operationalized as the inverse of the hopelessness score as measured by the Beck Hopelessness Scale (1974).

Measuring Hope: The Beck Hopelessness Scale

The Beck Hopelessness Scale was selected for use in this study because it is widely used in clinical settings, it is easy to self-administer, and it has proven to be a reliable and valid measure of negative expectancies or pessimism among people experiencing

various psychopathological conditions (Beck, Weissman, Lester, & Trexler, 1974; Holden & Fekken, 1988). Of all the instruments currently in clinical use, the Beck Hopelessness Scale is the best known and the most widely used. During the last decade 76 dissertations and masters level theses have utilized the Hopelessness Scale (Porowski, 1992).

The Hopelessness Scale was designed to operationalize hopelessness as a system of negative expectations concerning oneself and one's future life. Three factors were extracted from the 20 true/false items on the scale: (a) affective, (b) motivational, and (c) cognitive. The affective factor, Factor A, focuses on affective descriptors such as hope and enthusiasm, happiness, faith, and good times. This factor is labeled "Feelings about the Future." The motivational factor, Factor B, relates to the idea of giving up: deciding not to want anything, and not trying to get something that is wanted. Factor B is labeled "Loss of Motivation." The cognitive factor, Factor C, is labeled "Future Expectations" and includes anticipation about what life will be like: a dark future, getting good or bad things, things not working out, and a future that is vague and uncertain.

For the current study the Hopelessness Scale was modified with respect to response style. The content and order of the 20 items were not changed. The difference is that a 6-point Likert-type scale was used to respond to each item rather than true and false. A similar modification was made by Mercier, Fawcett, and Clark (1984), in response to the criticism that the Hopelessness Scale did not yield much variance in a community based, nonpsychotic, older population. Their scale asked people to respond by indicating how frequently they had felt a particular way in the past 2 weeks. The scale used in the current study asked participants to indicate the extent of agreement or disagreement that each particular statement was descriptive of them during the past week.

Hope then is the state of being characterized by confident belief that a valued goal is attainable now or in the future. The Beck Hopelessness Scale is conceptualized as a measure of the absence of hope. Now that construct of coping and definitions of hope have been presented, we shall briefly return to the importance of hope in coping.

The Importance of Hope in Coping

The establishment and maintenance of hope is considered essential in all of the psychotherapies (Yalom, 1985). Considerable research has focused on the importance of hopelessness in a variety of psychopathological conditions. Hopelessness has been identified as one of the core characteristics of depression (Beck, 1963, 1967; Melges & Bowlby, 1969), and has been implicated in a variety of other conditions such as suicide (Beck, 1963).

The findings of Herth (1989, 1990) add to the body of knowledge about the relationship between hope and coping. When the patient's level of hope was high, the level of coping response was high and when the patient's level of hope was low, the level of coping response was low. Patients who possessed a strong religious faith had a higher level of hope and a higher level of coping response than those who had a weak faith or were without faith.

This current research investigated whether belief in the resurrection contributes to higher levels of hope even when measured with different instruments and under different circumstances.

Near the beginning of this chapter the question was asked, "Why does one person feel hopeful and another feel hopeless when faced with similar stressors?" It was suggested that the difference may be determined by what one's hope is based on, or perhaps the individual's appraisal of the effectiveness of perceived coping options. It was suggested that multiple factors contribute to feelings of hopefulness or hopelessness. The following section addresses an often neglected perspective on hopelessness.

Biblical Perspectives on Hopeless Grieving

This current research was prompted by the following statement of the Apostle Paul, "But we do not want you to be uninformed brethren about those who are asleep, that you may not grieve, as do the rest who have no hope" (I Thessalonians 4:13, NASB). Taken in context, the implication is that when a person is aware of and believes in the resurrection, such a person's grief will be different from the grief of others who have no hope in the resurrection.

What is the Christian's hope? The Bible explains that Christ was crucified, died, and resurrected from the dead so that those who believe in Him would have

eternal life. The following passages describe the relationship of belief and eternal life:

> For God so loved the world that He gave his one and only Son, that whoever believes in him shall not parish but have eternal life. For God did not send his Son into the world to condemn the world, but to save the world through him. Whoever believes in him is not condemned, but whoever does not believe stands condemned already because he has not believed in the name of God's one and only Son. (John 3:16-18, NIV)

Near the end of his gospel John writes:

> Jesus did many other miraculous signs in the presence of his disciples, which are not recorded in this book. But these are written that you may believe that Jesus is the Christ, the Son of God, and that believing you may have life in his name. (John 20:30-31, NIV)

The Bible describes a relationship between hope, resurrection, belief and eternal life in the following passage:

> Praise be to the God and Father of our Lord Jesus Christ! In his great mercy he has given us new birth into a living hope through the resurrection

> of the dead, and into an inheritance that can never perish, spoil or fade - kept in heaven for you, who through faith are shielded by God's power until the coming of the salvation that is ready to be revealed in the last time. (I Peter 1:3-5, NIV)

According to the Bible, those who have put their faith in Christ will be resurrected and spend eternity with God. Being raised from the dead to live forever with God is a source of hope and encouragement to believers in Christ.

> We believe that Jesus died and rose again and so we believe that God will bring with Jesus those who have fallen asleep in him. According to the Lord's own word, we tell you that we who are still alive, who are left till the coming of the Lord, will certainly not precede those who have fallen asleep. For the Lord himself will come down from heaven, with a loud command, with the voice of the archangel and with the trumpet call of God, and the dead in Christ will be raised first. After that, we who are still alive and are left will be caught up together with them in the clouds to meet the Lord in the air. And so we will be with the

> Lord forever. Therefore encourage each other with these words. (I Thessalonians 4:14-18)

Spilka, Hood and Gorsuch (1985) wrote,

> Among the religious meanings associated with death is the concept of an afterlife, and few formulations seem as personally gratifying as the continuation of life following death. Few conceptions are as gratifying as life after death. We may be severed from our bodily existence with all its stresses and strains but still maintain the hope that the next world will bring a contrasting bliss. The essence of the issue is that we and our loved ones are preserved for eternity in a happy, everlasting reunion. (p.127)

The Apostle Paul makes it clear that the belief in the resurrection of Christ is central to the Christian faith. This is expressed in the following passages:

> For what I received I passed on to you as of first importance: that Christ died for our sins according to the scriptures, that he was buried, that he was raised on the third day according to the Scriptures, and that he appeared to Peter, and to the Twelve. After that he appeared to more than five hundred of the brothers at the same

> time, most of whom are still living, though some have fallen asleep. Then he appeared to James, then to all the apostles, and last of all he appeared to me also... (I Corinthians 15:3-7)
>
> But if it is preached that Christ has been raised from the dead, how can some of you say that there is no resurrection from the dead? If there is no resurrection from the dead, then not even Christ has been raised. And if Christ has not been raised, our preaching is useless and so is your faith. More than this, we are then found to be false witnesses about God, for we have testified about God that he raised Christ from the dead. (I Corinthians 15:12-15a)

Other Biblical passages demonstrate that Christ has power over death: the account of Jairus's daughter (Matthew 9:18-26, Mark 5:35-43), Lazarus (John 11:1-45) and others. The Bible provides a record of multiple appearances of Christ after His resurrection (Matthew 28:1-10, 28:16-20, Mark 16:1-18, Luke 24:1-49, John 20:1-21:23, Acts 1:3-8, and I Corinthians 15:5-7). Many other Old and New Testament passages could be presented which pertain to the resurrection, however the key points relevant to this research have been

sufficiently expressed in the examples given. Additional information about the resurrection can be found in I Corinthians chapter 15. One may also refer to Christian Theology (Erickson, 1985) and Evidence That Demands A Verdict (McDowell, 1972). In the book, Facing Death and the Life After, Billy Graham wrote,

> The Bible says we have a God of Hope. In scripture we find our hope. Having faith and hope does not mean that we bypass grief, but we can work through it and be strengthened by the experience... [I] spoke of death as being an enemy. Its companion, grief, does not need to be an enemy, but a process of life through which we can have a closer relationship with Jesus Christ, a stronger bond with other believers, and a greater out-reach to others. (Graham, 1987, p.177)

The Princeton study of Religion in America (Bezilla, 1993) explored several questions relevant to the current research. Participants were asked to indicate their agreement with the statement: "The only assurance of eternal life is personal faith in Jesus Christ." The 330 participants age 50 and older responded as follows: Agree completely 65%, Agree somewhat 12%, Disagree somewhat 8%, Disagree completely

8%, and 7% gave no opinion. They found that more people reported belief in heaven (78%) than reported belief in life after death (65%). It was suggested that this reflects different perspectives of heaven. It was also reported that fear of dying is low in the United States. "The survey evidence strongly suggests that few fear death because they fully anticipate there is a life hereafter, that likely will be in heaven" (Bezilla, 1993). This is consistent with Spilka, Hood, and Gorsuch (1985), who reported that research on the relationship of religion and death attitudes among the elderly are generally consistent and indicate that older religious individuals show little or no fear of death and usually possess spiritual and Biblical perspectives about death that include an afterlife (p. 139). Among the participants of the Princeton study of Religion in America, age 50 and older, 74% reported understanding why Christians celebrate Easter, with 26% reporting that they were not sure (N = 327, p. 48). Naturally, understanding why Easter is celebrated is not the same as personally believing in the resurrection of Christ, but is consistent with belief in the resurrection.

To conclude this section on Biblical perspectives of hopeless grieving we return to Campbell (1983) who pointed out, "Christianity is not just a cognitive endorsement of a set of beliefs, but a lifestyle (p.59)." Such a lifestyle is based on beliefs and values that not only affect the way people think and feel, but the way they behave and relate to others. Campbell also noted that the Bible has many passages relevant to coping which bring comfort to the Christian in times of distress. When confronting a stressful situation many Christians use religious coping strategies such as praying, reading the Bible, and asking others to pray for them. It is suspected that many bereaved spouses utilize spiritual beliefs and behaviors to cope with bereavement stress. The following section introduces hospice care, including spiritual care which is offered by hospice an important dimension of the holistic care.

Introduction to Hospice

Throughout history, caring for dying persons has primarily been the responsibility of families and religious groups. Care was emphasized since cure was

rare. Average life expectancy was short, and dying was usually a quick process. In recent years dying has increasingly become the experience of the elderly and is generally associated with long-term diseases. New approaches had to be developed for the care of the dying. Today there are many programs in England and in North America which offer the specialized palliative care of hospice. These programs are patterned after St. Christopher's Hospice in Sydenham, England and share goals largely developed by Dr. Saunders of England. Although Dr. Saunders began lecturing in the United States in 1963, the initial response of America society to the hospice concept was sparked by Dr. Elizabeth Kubler-Ross's (1969) book, On Death and Dying. Florence S. Wald, then dean of the Yale School of Nursing brought from St. Christopher's Hospice the hospice concept. In 1973 Wald applied for a 3-year demonstration grant which was awarded. The National Hospice Organization was incorporated in 1978 (Campbell, 1986).

Death can be extremely stressful for all involved, including the person who is ill and his/her loved ones. It is for this reason that the "hospice patient" is not just the person who is dying; rather hospice programs

care for the family as a whole (Oregon Health Division Report, 1988). To qualify for hospice care a person must be terminally ill, have ceased to want active treatment aimed at cure, and have a prognosis of less than 6 months to live.

The process of coping with bereavement is certainly unique for each individual, and yet there are many typical experiences associated with grieving that are experienced in physical, emotional, cognitive, social, and spiritual domains. Hospice programs recognize the importance of each domain as they seek to help individuals and families cope with bereavement. The hospice concept is focused on pain control, realizing that pain can be physical, psychological, spiritual, social or any combination of these. To meet such needs, hospice utilizes a multidisciplinary team which includes the following members: physician, nurse, social worker, spiritual counselor, bereavement counselor, and volunteers (Carlson, Murray, & Marthinson, 1985; Campbell, 1986).

The decision to study bereavement among spouses of hospice patients was made because hospice programs promote a holistic view of people which includes the person's spiritual beliefs. A second reason that

hospice programs were invited to participate in this research was because bereavement follow-up is an important service offered by hospice. It was anticipated that the multidisciplinary teams of hospice programs, and the hospice families, would value research on how a variety of coping behaviors and spiritual beliefs may influence the painful feelings of hopelessness that are sometimes associated with bereavement.

As a point of interest, 2/3 of hospice nurses reported belief in an afterlife which is overseen by a personal God. Of those 30% identified themselves as universalists while over 60% reported that God accepts only those deceased who have faith in Jesus Christ (Davis, 1990). In another study 93 hospice nurses responded to the question, "How important are your religious beliefs and practices?" On a 7-point likert scale, with 1 = No importance and 7 = Extremely important, the mean was 5.24 with a standard deviation of 1.68. Over 80% of the hospice nurses reported belief in an immanent God, about 15% reported belief in an unspecified higher power, and the remaining nurses identified themselves as either agnostic or atheist (Vosler, 1992, p. 81).

Summary

In this chapter research relevant to coping with bereavement was presented. Key points included the universally stressful nature of bereavement and examples of potential risks associated with bereavement (e.g. some bereaved individuals experience disabling feelings of hopelessness). Included was the finding that feelings of hopelessness are highly correlated with suicidal intent. It was suggested that to develop effective interventions to suicide one must understand the beliefs and behaviors that promote hope or contribute to hopelessness.

The literature review contained examples indicating the need for research on coping with bereavement and the need to explore spiritual beliefs and behaviors in such research. The effects of survivor's age, length of marriage, timeliness of death, financial status, education, and living environment have uncertain effects on how people cope with grief. It was shown that little is known about what people actually do to cope with bereavement stress. It was suggested that much of the scientific community lacks interest in exploring the effects

spiritual beliefs have on coping behaviors. Such a position reflects a major oversight in light of the finding that the general population ranks spiritual beliefs and behaviors as an important way of coping with stressful life events.

Three key variables in this research are coping behaviors, hopelessness, and resurrection beliefs. Coping was defined by Folkman and Lazarus as the cognitive and behavioral efforts to manage specific external and/or internal demands appraised as taxing or exceeding the resources of the individual. A variety of definitions and measures relevant to hope and hopelessness were also provided with special emphasis given to the Beck Hopelessness Scale. The Beck Hopelessness Scale is reliable, and is a valid measure of negative expectations concerning oneself and one's future life (based on affective, motivational, and cognitive factors). The general importance of hope in coping with a variety of stressors was identified. Also included in the literature review was a Biblical perspective on hopeless grieving and the centrality of the resurrection to Christian faith. Spiritual Coping is not completely absent from the literature. Examples

of studies which reported the importance of Spiritual Coping with a variety of stressors were presented.

Hypotheses

The principal purpose of this research with bereaved spouses of hospice patients was to investigate if there were quantifiable relationships in the domains of coping behaviors, spiritual beliefs, and hopelessness. More precisely, four research questions were explored: (a) Is there a relationship between coping behaviors and levels of hopelessness among bereaved spouses of hospice patients? (b) Is there a relationship between resurrection belief and levels of hopelessness among bereaved spouses of hospice patients? (c) Will bereaved spouses of hospice patients who report a strong belief in the resurrection use different coping behaviors than those who do not hold such beliefs? (d) Will bereaved spouses of hospice patients who spontaneously report spiritual beliefs or behaviors as their primary method of coping with their most difficult bereavement stressor differ in levels of hopelessness when compared to those whose primary way of coping was non-spiritual.

Each of the four research questions was reconstructed to form four null hypothesis. Each hypothesis is presented along with its accompanying rationale based on the literature review. The current research investigated the following null hypotheses:

H1: Coping behaviors, as measured by the Ways Of Coping Questionnaire-Revised, will not be significantly related to Beck Hopelessness scores.

Rationale for H1: In consideration of Worden's 4 tasks of mourning, Lazare's 12 clues of unresolved grief, and the Biblical literature presented, it was anticipated that participants who primarily coped with bereavement by utilizing thoughts and behaviors defined as Positive Reappraisal, Planful Problem Solving, or Spiritual Coping, would report less Hopelessness than participants who primarily utilized Distancing, or Escape-Avoidance.

H2: Bereaved spouses who report strong belief in resurrection will not significantly differ in Beck Hopelessness scores from bereaved spouses who do not hold such beliefs.

Rationale for H2: I Thessalonians 4:13 indicates that a person who believes in the resurrection will not grieve as others who have no hope. Previous research

demonstrated that participants who reported strong religious faith had significantly higher mean scores on the Herth Hope Scale and the Jalowiec Coping Scale than the mean score of the other four groups (Weak, Unsure, Lost, or Without Faith). It was anticipated that a similar outcome would be evident using the Beck Hopelessness Scale.

H3: There will be no significant differences in reported coping behaviors, as measured by the Ways of Coping Questionnaire-Revised, among bereaved spouses who report strong belief in resurrection and those who do not hold such beliefs.

Rationale for H3: Cognitive therapist maintain that beliefs influence motivation and behaviors. It was anticipated that participants who strongly believe in resurrection would more frequently choose Spiritual Coping behaviors to manage bereavement stress than participants who do not hold such beliefs. Previous research indicated that religious behaviors were prevalent coping behaviors. It was also anticipated that participants who strongly believe in the resurrection would select Escape-Avoidance options less frequently than participants who did not hold such beliefs.

H4: There will be no significant difference in Beck Hopelessness Scores among bereaved spouses who spontaneously report spiritual beliefs or behavior as their primary method of coping with bereavement and those who report non-spiritual methods as their primary way of coping with bereavement stress.

Rationale for H4: Spontaneous reporting was considered to be a measure of one's actual beliefs and values. It was anticipated that participants who spontaneously reported Spiritual Coping behaviors would report less hopelessness than participants who primarily coped by using other options. Koenig, Moberg, and Kvale (1988) reported that religious activities and attitudes explained more of the variance in well-being than any variable except health. Koenig, George, and Siegler (1988) concluded that religious attitudes and activities are the predominant coping behaviors reported by older adults.

CHAPTER 2

METHODS

An account of all the information relevant to the collection of data for this research is provided in this chapter. Information pertaining to participants includes a description of participating hospice programs and a description of the bereaved spouses who volunteered to take part in this research. Information about the instruments includes a presentation on the development of the Demographic Questionnaire and a presentation on the development of the Inventory of Coping Responses. A description of the Beck Hopelessness Scale and a description of the Ways Of Coping Questionnaire-Revised is also provided, including a presentation of their psychometric properties. Details concerning how each aspect of this

research was conducted are presented in the procedures section. Finally, a description of the research design is given and an account of data collection and analysis for each hypotheses is provided.

Participants

The five participating hospice programs were based in four Oregon counties and one Washington county. Hospice programs were located in the following Oregon counties: Clackamas, Multnomah, Washington, and Yamhill. A Hospice located in Clark County, Washington also participated. Each of the program directors received a participation proposal introducing the research (Appendix A). The participating hospice programs helped recruit participants by sending a letter to potential participants introducing the research (Appendix B). Bereaved spouses from participating programs were invited by personal letter to participate in the study (Appendix C). Of approximately 300 individuals contacted, 100 volunteered to participate and completed the survey. All responses were anonymous. The data from two potential participants was excluded because of major

omissions of responses. A third set of data was not used because the participant responded to questions in reference to his first spouse who died approximately five years ago. All of the 97 remaining participants were recently bereaved (Range 1 to 16 months, Mean 7.5 months, and Standard Deviation of 4.3 months). Females comprised 76% of the participants. The mean age of the female participants was 67.4 years with a standard deviation of 11.9. The mean age of the male participants was 60.6 years, with a standard deviation of 15 years. The majority of participants (67%) expressed a strong belief in a resurrection from the dead, while 4.4% strongly disagreed with a belief in the resurrection. The remaining participants indicated slight to moderate agreement or disagreement concerning the resurrection (see Table 7, in the following chapter).

Instruments

Four instruments were used in this study. Each instrument will be presented in some detail. The instruments included: (a) two forms of a demographic questionnaire designed by the author, (b) the Beck

Hopelessness Scale (Beck et al., 1974), (c) The Ways Of Coping Questionnaire-Revised (Folkman & Lazarus, 1988) and (d) The Inventory of Coping Responses, also designed by the author.

Demographic Questionnaire

Two versions of the demographic questionnaire were used, each designed according to Dillman's (1978) model for self-administered surveys. Both the original and the revised version gathered demographic information concerning the participant's age, sex, cause of the spouse's death, number of months since the death of the spouse, and open ended questions about coping. In addition, the Demographic Questionnaire-Original (Appendix E) included eight statements describing different beliefs pertaining to what happens after death. Participants indicated the extent of their agreement or disagreement with each statement by responding to a 6-point likert-type scale. The Demographic Questionnaire-Revised (Appendix F) was different from the original in two important ways. The first difference was that the revised version included a statement acknowledging the participant's right to believe as he or she chooses. The second important

difference was that the revised demographic scale eliminated all but two of the Likert-type statements relevant to after life beliefs. The two retained statements provided an opportunity for participants to indicate the extent of their agreement or disagreement with a belief in the resurrection to eternal life, and the belief that there is no after-life of any kind. The revisions were made to accommodate the request of the hospice program in Washington. Approximately half of the participants responded to the original demographic questionnaire and half responded to the revised version. For purposes of this research, belief in the resurrection was operationalized as a response of "strongly agree" to the statement: "I believe that people who have been spiritually reborn through faith in Jesus Christ will be resurrected from the dead to live eternally with God."

The Beck Hopelessness Scale

As indicated in chapter 1, hopelessness can be understood to be the absence of hope, or the opposite of hope. For purposes of this study, hope will be defined as the inverse of hopelessness as measured by the Beck Hopelessness Scale (Beck, Weissman, Lester, &

Trexler, 1974). Since the Beck Hopelessness Scale is copyrighted it was not included in the appendix.

The Beck Hopelessness Scale (BHS) is a 20-item, true/false, self-report inventory that assesses pessimistic cognitions. Scores range from 0-20, with 0-3 indicating no or minimal hopelessness; 4-8 mild; 9-14 moderate; and 15-20 severe hopelessness. For purposes of the present research participants responded on a 6 point Likert scale to indicate the extent that each statement was or was not descriptive of them during the past week. Thus the adjusted range of the scale was 20-120.

Reliability

A population of 294 hospitalized patients who had made recent suicide attempts provided the original data for determining the internal consistency of the BHS. The internal consistency of the scale was analyzed by means of coefficient alpha (KR-20), which yielded a coefficient of .93 (Beck et al., 1974). Holden and Fekken (1988) examined test-retest reliability over a three week period and found high reliability. Test-retest reliability was .85 for the entire sample, .94 for males and .67 for females. The lower value for females reflected a more limited range in that sample.

Validity

The concurrent validity was determined by comparing HS scores with clinical ratings of hopelessness and with other tests designed to measure negative attitudes about the future. Strong correlations were found with the clinical rating of hopelessness (r = .74, p < .001), and with hospitalized patients who made recent suicide attempts (r = .62, p < .001). The correlation with the Pessimism item of the Beck Depression Inventory (Beck, 1967) was .63 (p < .001).

Construct validity was provided by using the BHS as a measure in testing various hypotheses relevant to the construct of hopelessness. The BHS was used in several studies, and in each case, the hypothesis was confirmed. These findings support the construct validity of the Beck Hopelessness Scale (Beck et al., 1974).

Factorial validity was established from the data obtained from 294 suicide attempters. Three factors were: (a) Feelings about the Future, (b) Loss of Motivation, and (c) Future Expectations (Beck et al., 1974).

Beck et al. (1974) concluded that the data presented for the BHS are sufficient to justify its use on a continuing basis.

The Ways Of Coping Questionnaire-Revised

The Ways of Coping Questionnaire-Revised (WOCQ-R) has a long history which is briefly presented in this section. (Since the Ways of Coping Questionnaire-Revised is copyrighted it was not included in the appendices.) In 1980 Folkman and Lazarus put forth the original Ways of Coping Checklist. The 68 items on the original instrument were classified on the basis of rater's judgments as being "problem-focused" or "emotion-focused" (Folkman & Lazarus, 1980). Problem-focused coping referred to efforts to manage or change person-environment relationship that is the source of stress, while emotion-focused coping referred to efforts made to regulate stressful emotions. These coping functions were also recognized, implicitly or explicitly, by Mechanic (1962), Kahn, Wolfe, Quinn, Snoek, and Rosenthal, (1964); Lazarus (1966, 1968), George (1974), Lazarus, Averill, and Opton (1974); Murphy (1974); White (1974); and Pearlin and Schooler (1978). Although this classification was a useful

first step, it failed to reflect the complexity of the human coping process. Furthermore, certain coping strategies were found to serve both problem-focused and emotion-focused functions. For those reasons, the original two scales are no longer used (Folkman & Lazarus, 1988).

Because of the problems identified with the rationally derived scales, Coyne, Aldwin and Lazarus (1981) used empirical methods to identify various ways of coping. This involved a factor analysis of the original community residents age 45-64, who reported how they coped with events of daily living. Those scales were also retired because subsequent factoring yielded clearer scales. Later, using the revised WCQ, two additional sets of data were factor-analyzed. One set of data was from community-residing married couples who reported on how they coped with events of daily living (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). The second set of data was from a sample of college students who reported how they coped with examination stress (Folkman & Lazarus, 1985). Because the data from the married couples represented a broad sample of individuals and stressful events, this

factoring was used as the basis for the Way of Coping Questionnaire.

The Ways of Coping Questionnaire-Revised (WOCQ-R) developed by Folkman and Lazarus (1988) was derived from a transactional model of stress (Aldwin, Folkman, Shaefer, Coyne & Lazarus, 1980). In this model an event is considered stressful when a person appraises it as potentially dangerous to his or her psychological well-being (Lazarus, 1966). It was theorized that such an appraisal may be influenced by a person's beliefs or personality, and may generate cognitive expectations which affect both emotions and behavior (Vitaliano, Russo, Carr, Maiuro & Becker, 1985). The Ways of Coping Questionnaire has been used extensively in studies examining the coping process (Tennen & Hewzberger, 1985; McCrae, 1982, 1984; Vitaliano et al., 1985). A review of research with the Ways of Coping Questionnaire is included in the Manual for the Ways of Coping Questionnaire Research Edition, (Folkman & Lazarus, 1988).

The WOCQ-R is a 66-item self-report questionnaire designed to identify the thoughts and actions individuals use to cope with a specific stressful situation. Respondents are instructed to evaluate each

coping strategy in relation to a specific stressful situation and indicate the frequency with which they use each particular coping strategy. Responses are recorded on a 4-point Likert scale of frequency: 0 = "not used", 1 = "used somewhat", 2 = "used quite a bit", and 3 = "used a great deal."

The sample from which the coping scales were developed was composed of 75 middle- and upper-middle-class white married couples who had at least one child living at home. Once a month, over a 5 month period, each marriage partner was asked to describe the most stressful encounter of the past week and then completed the Ways of Coping Questionnaire. Observations from the interviews were pooled and analyzed.

The coping scales came about after performing three separate factor analyses of data. An oblique rotation was selected for factoring because individuals were expected to choose from an array of coping strategies rather than to use one set of strategies to the exclusion of others. The three factor analyses yielded similar factor patterns: 37 items consistently loaded high on the same factor for all 3 analyses; 22 items loaded on the same factor fairly consistently; however 9 were eliminated due to marginal factor

loading or lack of conceptual coherence with their scale; and 7 items were eliminated because they did not consistently load on any single factor. A final principal factor analysis was performed on the 750 observations with the final 67 items to provide an estimate for each item's loading. This resulted in the following 8 scales that were introduced in Table 2 of chapter 1: (a) Confrontive Coping, (b) Distancing, (c) Self-Controlling, (d) Seeking Social Support, (e) Accepting Responsibility, (f) Escape-Avoidance, (g) Planful Problem Solving, and (h) Positive Reappraisal.

In earlier versions of the Ways of Coping Questionnaire there were no items addressing religious coping strategies. In a study addressing coping with hemodialysis, Campbell (1983) expanded the instrument that was current at the time (Ways of Coping Checklist), by adding six religious coping items to the end of the instrument. Campbell's items were rationally derived from what he believed were common coping strategies among Christians. His six items were:

1. Prayed about the situation.
2. Asked someone to pray with you about the situation.

3. Asked someone to pray for you about the situation.
4. Searched the scripture for spiritual insight or comfort.
5. Reflected on spiritual thoughts such as "God is in control of my life in this situation."
6. Talked with a priest, minister, or rabbi about the situation.

Folkman and Lazarus included two religious coping options in the revised questionnaire: "I found new faith", and "I prayed." Because Spiritual Coping was a key aspect of the current investigation, four of Campbell's items were added, to the end of the WOCQ-R. These items were:

1. I asked someone to pray with me about the situation.
2. I searched the Bible for spiritual insight or comfort.
3. I reflected on spiritual thoughts such as "God is in control of my life in this situation."
4. I talked with a priest, minister, or rabbi about the situation.

The four items from Campbell and the two religious items of Folkman & Lazarus were used by this author to comprise a scale referred to as: Spiritual Coping.

The scales of the Ways of Coping Questionnaire-Revised each have between four to eight items, many scales have six items (Table 3). The two items of religious coping listed by Folkman & Lazarus were re-coded to load on the Spiritual Coping scale.

Reliability

"Because the Ways of Coping Questionnaire measures coping processes, which, by definition are variable, traditional test-retest estimates are inappropriate" (Folkman & Lazarus, 1988, p. 13). However, reliability can be evaluated by examining the internal consistency of the coping measures, estimated with Cronbach's coefficient alpha. Folkman and Lazarus (1988) reported that internal consistency estimates of coping measures generally fell at the low end of the traditionally acceptable range, and reported alpha coefficients ranging from .61 to .79. They note the findings of Billings and Moos (1981) that people constructing coping measures attempt to minimize item redundancy within each coping category, resulting in groups that

are of relatively independent clusters of coping strategies in each category. Furthermore, the use of one coping response may produce the desired effect, thus reducing the need and probability that other coping responses from the same category will be used. Folkman and Lazarus (1988) report that the alpha coefficients for the eight scales, shown in Table 3, are higher than the alpha coefficients reported for most other measures of the coping process.

Table 3

Internal Consistency of Coping Scales Averaged Over Five Occasions

Scale	No. of Items	Mean	SD	Alpha
1. Confrontive Coping	6	3.94	2.09	.70
2. Distancing	6	3.05	1.78	.61
3. Self-Controlling	7	5.77	2.87	.70
4. Seeking Social Support	6	5.40	2.40	.76
5. Accepting Responsibility	4	1.87	1.44	.66
6. Escape-Avoidance	8	3.18	2.48	.72
7. Planful Problem Solving	6	7.25	2.34	.68
8. Positive Reappraisal	7	3.48	2.96	.79

Note. N = 150. The data in Table 3 is from Folkman and Lazarus (1988).

Table 4

Intercorrelations of Coping Scales Averaged Over Five Occasions

Scale	1	2	3	4	5	6	7	8
1. Confrontive Coping		.01	.36	.27	.26	.27	.27	.26
2. Distancing			.36	-04	.27	.32	.09	.13
3. Self-Controlling				.24	.30	.36	.37	.39
4. Seeking Social Support					.09	.23	.30	.32
5. Accepting Responsibility						.39	.13	.18
6. Escape-Avoidance							.10	.23
7. Planful Problem Solving								.39
8. Positive Reappraisal								

Note. N = 150. The data in Table 4 is from Folkman and Lazarus (1988).

Validity

Folkman and Lazarus (1988) report: "The items on the Ways of Coping Questionnaire have face validity since the strategies described are those that individuals have reported using to cope with the demands of stressful situations" (p. 14). They state

that evidence of construct validity lies in the fact that the results of their studies are consistent with their theoretical predictions that: (a) coping consists of both problem-focused and emotional focused strategies, and (b) coping is a process. This is to say that how people cope varies in relation to the demands and constraints of the context and in relation to changes in those domains as an encounter unfolds. The importance of assessing both emotion-focused and problem-focused functions was further supported by subsequent research using the original Ways of Coping Checklist (Braukmann, Filipp, Angleitner, & Olbrich, 1981; Heppner, Reender, & Larson, 1983; Kirmeyer & Diamond, 1985; and Manne & Sandler, 1984).

The Inventory of Coping Responses

To assess the fourth hypothesis, which explored the relationship of Spontaneously Reported Coping Behaviors and Hopelessness, required the development of an inventory to classify coping behaviors. A sample of the Inventory of Spontaneous Coping Responses (ISCR) appears in Appendix J. The ISCR provided a method for numerically coding spontaneously reported coping responses into distinct groups and provided data

necessary for the assessment of interjudge reliability regarding the numeric coding of spontaneously reported coping responses.

The inventory was developed by recording the 97 participant's spontaneous answers to an open-ended question which essentially asked, "What is your primary way of coping with bereavement stress?" Responses were defined as spontaneous because there were no forced choice options and the question appeared early in the survey to avoid the possible influence of other questions or response options. Based on a review of responses, the author selected the following broad categories of coping behavior for the judges to consider: (a) Activity to Keep Busy, (b) Family, Friends, or Social Coping, (c) Spiritual Coping, and (d) Other. Judges utilized the inventory to identify one or more categories descriptive of each coping response.

Procedures

The procedures described in this section include: Human participant approval, permission to use instruments, pilot study, feedback and modifications,

recruiting hospice programs, identifying participants and recruiting participants.

Human Participant Approval

Approval for this study was secured from the Human Subjects Committee of George Fox College according to standard protocol, including the agreement to treat all participants according to the ethical standards of the American Psychological Association.

Permission To Use Instruments

Letters requesting permission to use the Ways Of Coping Questionnaire and the Beck Hopelessness Scale as instruments for this research were sent to the appropriate individuals and organizations. Aaron Beck granted permission to use the Beck Hopelessness Scale and Susan Folkman and Consulting Psychologist Press granted permission to use the Ways Of Coping Questionnaire-Revised.

Pilot Study

A brief pilot study was conducted which invited 14 members of a bereavement support group to anonymously complete a survey on coping with bereavement. Surveys

were given to each participant by the support group leader. Each participant was provided with a post-paid return envelope addressed to the research director. Eight surveys were completed. The purpose of the pilot study was to gain feedback on the survey concerning: (a) the amount of time required to complete the survey, (b) complaints and/or suggestions for improving the study, and (c) whether participants would be willing to respond to each part of the survey. The information was used in the development of the introductory letter, instructions, and demographic questionnaires.

Feedback and Modifications

A funeral chapel director, a bereavement coordinator from hospice, the responses to the pilot study, and the chairperson of this study provided the initial feedback on the proposed research. This collective input prompted the following modifications of part one of the survey. A question was added so each participant could indicate how his or her spouse died. That question was included to help the participant "tell his or her story" and to help personalize the survey. The next change replaced a "circle the number" response with a question asking the

participant to write in the month and year of the death. This change was made to help focus the participant on the event, and to avoid the possibility of implying that grieving was limited to the number of months which were included as options. A third change was an increase in the number of items describing beliefs about what happens after death. This change was made to accommodate a wider range of responses and thus reduce the potential for offending someone because his or her spiritual beliefs were not represented. However, this solution did not satisfy all of the hospice programs and therefore the second demographic questionnaire previously described was implemented. Accepting the impossibility of listing all possible beliefs about the after-life, the questionnaire confirmed the participant's right to believe as he or she chose and provided a space where participants were encouraged to express their own beliefs. Lastly, questions about potential changes in one's confidence in beliefs concerning God's sovereignty, wisdom, and love were deleted and replaced with a more general open-ended question: "In what ways, if any, has the death of your spouse affected your spiritual beliefs, spiritual behaviors and feelings about God?" The

change was made to allow for a wider range of spontaneous responses.

Recruiting Hospice Programs

Seven hospice programs were invited to participate in the current research. Six were from four different Oregon counties (Clackamas = 1, Multnomah = 1, Washington = 3 and Yamhill = 1) and one program was from Clark County, Washington. Two programs from Washington County in Oregon elected not to participate. Each of the five participating program served over 100 families per year. Two programs were hospital-based, two were community-based, and one had its own residential program.

Each of the program directors received a participation proposal introducing the research (see appendix A). Appointments were made with program directors and bereavement coordinators so they could examine the research materials, including an introductory letter inviting participation (Appendix C), general instructions and overview of the survey (Appendix D), and the three part survey. The Survey included: Section 1, one Demographic Questionnaire (Appendix E or F), Section 2, the Ways Of Coping

Questionnaire-Revised, and Section 3, Beck's Hopelessness Scale. (Both the WOCQ-R and the BHS are copyrighted and thus not included in the appendices). The hospice directors and bereavement coordinators were also shown a copy of the instructions for mailing and tracking surveys (Appendices G and H) and follow up letter reminding participants to return surveys (Appendix I). An overview of the research was verbally presented to the director and/or bereavement coordinator from each program. These individuals examined the materials and were encouraged to ask questions and given an opportunity to give feedback.

Identifying Participants

Directors or bereavement coordinators from the participating hospices searched their files to identify individuals whose spouses died not less than one month ago. They started with the most recent losses and worked back until they had names and addresses of 50-75 bereaved spouses. The participating hospices then addressed the envelopes containing the surveys that were supplied by the director of this research. Each envelope had a code number which the hospice director

or bereavement coordinator recorded for keeping track of surveys received (Appendix H).

Each hospice kept the records of names, addresses, and the code number of each participant, which enabled sending of follow-up letters reminding people to return their surveys. To protect anonymity of respondents, all data was sent directly and anonymously to the research director. Thus the hospice staff could not match the names of the participants with the data. The research director, in turn, never saw the list of names and addresses. The records of names and addresses were destroyed three weeks following the mailing of the survey. That procedure insured confidentiality and yet provided a way to identify participants who were late in responding so that follow-up letters reminding those people to return their surveys could be sent.

Recruiting Participants

Research packets were mailed to each potential participant. Enclosed was a letter from the hospice director introducing the study (Appendix B) and a letter from the research director which briefly described the study and invited him or her to participate (Appendix C). The research packets also

included: written general instructions and an overview of the survey (Appendix D), Demographic Questionnaire (Appendix E or F), the Ways of Coping Questionnaire-Revised, and Beck's Hopelessness Scale. Pre-addressed postage-paid envelopes were provided for response convenience. A follow-up letter (Appendix I) was sent to non-respondents approximately 7-10 days after the survey was mailed to the potential participant.

Participants were given an overview of the entire study, as well as detailed instructions for each part of the survey. They were told that participation was voluntary and that they had the option to discontinue responding to the survey at their discretion. Participants were instructed not to write their names on any of the research materials as a means of insuring confidentially. They were also given instructions that surveys should be completed in a quiet environment without seeking interpretations from other people. Detailed instructions for particular items were provided as one read through the survey.

Coding Spontaneously Reported Coping Responses

Coding spontaneously reported coping behaviors, in preparation for data analysis, required four steps:

(a) collection of participant's coping responses (see: Defining Spontaneously Reported Coping), (b) responses of each participant were recorded to generate the Inventory of Coping Responses, (c) judges identified which specific coping options were descriptive of each response (see: Judging Coping Options), and (d) the selected coping options were each converted into numeric coping categories relevant to coping behaviors and hypothesis four (see: Numeric Coping Categories of Spontaneously Reported Coping Behaviors).

Defining Spontaneously Reported Coping Responses

Participants were asked, "Since the death of your spouse, what has been the most difficult thing for you to cope with?" They were also asked, "What is your primary way of coping with this stressor?" (Appendix E or F) The participant's responses were deemed spontaneous because, (a) the questions were open ended with no forced choice options, and (b) these coping questions preceded all questions about afterlife beliefs, spiritual beliefs, and items from the Ways Of Coping Questionnaire-Revised. Thus the potential influence of said items was eliminated and such contamination was avoided.

Categorization of Spontaneously Reported Coping Responses

The 97 actual coping behaviors spontaneously reported by the participants were compiled by the research director. Each response was recorded in the approximate order it was received, including the "no answers." The list of responses was utilized to generate the Inventory of Spontaneous Coping Responses (Appendix J). While responses were being compiled it was observed that many of the coping responses could be described by broad categories relevant to this research. These categories were given the following labels:

A = Activity to Keep Busy

F = Family, Friends, or Social coping

S = Spiritual Coping

O = Other

A panel of judges completed the response inventories to categorize coping behaviors as described in the following section.

Judging Coping Options

A panel of four volunteer judges classified the spontaneously reported coping responses. The panel

consisted of one woman and three men. Two judges hold masters degrees in psychology, one judge has a masters degree in social work, and one has a doctorate in psychology. Judges were instructed to discern which, if any category was most descriptive of the coping behavior. Judged were given the following instructions:

> Please read each response carefully and determine which of the following 4 categories describe each response:
>
> A = Activity to Keep Busy
>
> F = Family, Friends, or Social Coping
>
> S = Spiritual Coping
>
> O = Other
>
> Use your best judgement to discern which if any category is most descriptive of the coping behavior. When the coping behavior is uniquely described by one category circle only one letter, either: "A", "F", "S", or "O". If the coping behavior(s) is (are) best described as "A+F", "A+S", "S+O" or any other combination, please circle EACH LETTER THAT IS APPLICABLE TO THAT COMBINATION of coping behaviors.

(See Appendix J: Inventory of Spontaneous Coping Responses)

Numeric Coding of Spontaneously Reported Coping

Because participants often responded with more than one "primary" coping response it was necessary to allow the judges to select more than one of the above categories. Such flexibility allowed for many different coping options, which were then classified into one of the seven options as defined by the following numerically coded coping groups:

1 = Activity to Keep Busy ("A" only)

2 = Family, Friends, and Social ("F" only)

3 = Spiritual Coping ("S" only)

4 = Spiritual Coping combined with other options ("S" + any combination of responses)

5 = Other ("O" only)

6 = Combination of responses excluding spiritual coping. (Any combination of responses excluding "S")

7 = No answer (Reflecting no response from the participant. Each judge responded to every item.)

Classification of an item was based on the most common rating of the four raters. In the cases where raters were equally split between two categories the classification was based on the ratings of a preselected rater (rater #4). A Pearson correlation was run to assess the interjudge reliability of the four judges regarding the classification of coping methods. The interjudge reliability is shown in Table 5.

Table 5

Interjudge Reliability of Spontaneous Coping Method

	Rater 1	Rater 2	Rater 3	Rater 4
Rater 1	1.000			
Rater 2	.756**	1.000		
Rater 3	.876**	.732**	1.000	
Rater 4	.609**	.713**	.703**	1.000
RA-CORR	.806**	.862**	.859**	.799**

Note: ** Significant level .01

Data Analysis

Data Collection and Analysis

Data collection took place in March-June, and September-October 1994. Before data was entered into the computer to be analyzed by the SPSS/PC+ program (Norusis, 1988) some simple calculations were made, namely determining the number of months since the death of each spouse. Information concerning spontaneously reported ways of coping was compiled by the research director so the panel of judges could classify the reported coping behaviors as described in the methods sections pertaining to coding data.

Different statistical analyses were conducted relevant to the nature of each hypothesis. The statistics used for each hypothesis are presented here, followed by the rationale of each statistic including assumptions for the valid use of each particular statistic.

A Pearson correlation was used to examine the first hypothesis to determine if coping behaviors identified by the WOCQ-R and Spiritual Coping were related to Beck Hopelessness Scale scores. For the second hypothesis a one-way analysis of variance was

used to determine if Belief in the Resurrection was related to scores on the Beck Hopelessness Scale. For hypothesis three a discriminant analysis was used to determine if Strong Resurrection Beliefs were predictive of coping behaviors as reported via the WOCQ-R and Spiritual Coping. Hypothesis four was evaluated using a one-way analysis of variance to determine if Spontaneously Reported Ways Of Coping were related to Hopelessness. Before this analysis could be preformed, spontaneously reported coping responses were coded as presented in the methods section on coding responses. Recall that four judges each completed the Inventory of Coping Responses. A Pearson correlation was used to assess interjudge reliability.

When using a descriptive method of research one can virtually study any variable in virtually any situation. Descriptive statistics are used to discover whether a relationship exists between the variables one desires to explore. There is however a research cost in using the descriptive method. Without being able to manipulate variables, or account for the effects of extraneous variables, one can not infer causality. Although causation can not be proven with a survey and statistics, it is possible to discover where

relationships may exist. Such relationships suggest direction for further scientific exploration.

The first hypothesis was analyzed using a Pearson correlation to determine if coping behavior scores of the eight WOCQ-R factors and Spiritual Coping were related to Hopelessness scores. To understand correlation, visualize a scattering of points on a graph. For the current study the points were the scores of various coping behaviors (WOCQ-R + S), plotted by hopelessness score. Paraphrasing Mitchell and Jolley's (1988) explanation of the logic behind the Pearson *r*.: Basically, the Pearson *r* is calculated by drawing a straight line through the points of the scatter plot. If the line slopes upward, and every point in the scatter plot fits exactly on that line, the correlation is a perfect positive correlation of +1.00. Usually, however, there are points that are not on the line. Every point not on the line must be given due consideration. The farther a point is from the line the larger the value that is subtracted. Therefore for each point not on the line, the correlation coefficient is made closer to zero. When all misfit points are accounted for, the end result is known as the correlation coefficient. The correlation

coefficient describes the nature of the linear relationship between variables (pgs 272-4).

For hypothesis two a One-Way Analysis of Variance was used to determine if strong belief in the resurrection was related to scores on the Beck Hopelessness Scale. Most researchers use analysis of variance to understand multiple-group data. To use analysis of variance, observations must be independent, scores should be normally distributed, each group should have the same variance, and interval data must be used. In analysis of variance an F ratio is established: a ratio of the between group variance to the within-group variance (Mitchell & Jolley, 1988). To measure within-group variability we first calculate the variance of scores within each group. In this hypothesis there are two groups. The first group was comprised of all participants who reported strong belief in resurrection. The second group was comprised of all participants who reported less than strong belief in resurrection, ranging from moderate belief in the resurrection all the way to strong disagreement with belief in the resurrection. Since there are two groups, there are two measures of within-group variability - or two estimates of random error which

are averaged to establish the best estimate of the degree to which individual scores are affected by random error - the within group variance.

Once the within-group variability has been measured the next step is to compute an index of the degree to which groups vary from one another. Between-group variance should be the sum of two quantities: an estimate of the degree to which individual scores are affected by random error + any treatment effects.

For the third hypothesis a discriminant analysis was used to determine if strong resurrection beliefs were predictive of coping behaviors as reported via the WOCQ-R. Discriminant analysis is a statistical technique used to determine if a set of variables can predict (classify) certain discrete categories (Dillon & Goldstein, 1984, p. 360). In this study, discriminant analysis was used to formulate a linear model utilizing resurrection beliefs to predict use of coping behaviors. Dillon and Goldstein (1984) explain that discriminant analysis works by deriving linear combinations between defined groups in such a way that misclassification errors are minimized (p. 361). The two primary goals are analysis and classification. Analysis refers to finding the dimension or dimensions

along which groups are maximally different. Classification involves the ability to predict group membership on the basis of those predictor variables used to create the dimensions.

An equation is derived in discriminant analysis known as the discriminant function. Kachigan (1982) explains, "The discriminant function uses a weighted combination of those predictor variable's values to classify an object into one of the criterion groups" (p. 219). In symbolic form, the discriminant function is expressed as the following equation: $L1 = b1x1 + b2x2 + \ldots bkxk$. In the equation "L" is the subject's discriminant score, "x" represents the values of the various predictor variables, and "b" represents the weights associated with each of the respective predictor values. Participants are assigned to different groups depending on the relation of the participant's discriminant score and the cutoff score (Kachigan, 1982).

There are a number of key assumptions which must be met when using discriminant analysis. First, Klecka (1980) indicates that the two or more classification groups must be mutually exclusive. They must be defined in such a way that membership in one group

precludes membership in any other group. For example resurrection belief must be defined in such a way that each participant belongs to only one group. In this study participants either strongly believed in resurrection or they did not strongly believe in resurrection. A second key assumption is that, no variable may be a linear combination of another discriminating variable due to the problems with redundancy. Third, each group must be drawn from a population which has a multivariate normal distribution. The variances of a given variable must be the same in each criterion group population. Fourth, validation of the discriminant function and its ability to accurately classify is an important consideration. Kachigan (1982) asserts this should be done using a cross validation sample to avoid results that are spuriously high.

Hypothesis four was evaluated by using a one-way analysis of variance to determine if spontaneously reported spiritual ways of coping or non-spiritual ways of coping were related to hopelessness. The description of analysis of variance presented in reference to hypothesis two also pertains to hypothesis four. Before performing the analysis of variance for

the fourth hypothesis, the spontaneously reported coping responses were coded as described in the methods section. A Pearson correlation was used to assess interjudge reliability of the four judges. The description of correlation presented in reference to the first hypothesis also applies to correlation of interjudge reliability.

CHAPTER 3

RESULTS

The results of the statistical analyses conducted to evaluate each of the hypotheses are reported in this chapter. The results are presented in five sections. The first section presents demographic and descriptive data, sections two through five present the results from the four hypotheses. The chapter concludes with a summary of the results.

Demographic and Descriptive Data

Demographic and descriptive data were collected using two versions of a demographic questionnaire described in chapter 2 and presented in Appendices E and F. The demographic results compiled from questions common to both forms are reported in Table 6.

Table 6

Descriptive Characteristics of Bereaved Spouses

AGE	Mean	S.D.
Male Participants	60.5	15.0
Female Participants	67.4	11.8
Total Participants	65.9	12.8
PARTICIPANT'S GENDER	Frequency	Percent
Male	21	21.6
Female	76	78.4
CAUSE OF SPOUSES DEATH		
Heart Attack, Stroke or Sudden Physical Condition	03	03.1
Cancer, Aids, Chronic Disease or Other Lingering Illness	83	85.6
Accident, Suicide, Murder	10	10.3
Missing Cases	01	01.0
MONTHS SINCE DEATH OF SPOUSE		
Range:	1-16	
Mean:	7.6	
Median:	7.0	
Standard Deviation:	4.3	

Note: N = 97

The mean age of all 97 participants was 65.9 years with a standard deviation of 12.8 years. The mean age of the 21 male participants was 60.5 years with a standard deviation of 15.0 years. The mean age of the 75 female participants was 67.4 years with a standard deviation of 11.8 years.

The majority (85.6%) of participants had been married to individuals who died of lingering illnesses such as cancer, chronic disease, or AIDS. The lives of 3 individuals (3.1%) were claimed by heart attack, stroke or other sudden physical condition, and 10 individuals (10.3%) died as a result of accident, suicide, murder or other. There was one missing case (1.0%). The range of time since death was 1-16 months with a mean of 7.6 months, the median was 7 months, and the standard deviation was 4.3 months.

The results from questions pertaining to belief in the resurrection have been compiled in Table 7. As indicated, 67% reported strong belief in the resurrection. An additional 11.1% and 7.7% reported moderate and slight belief in the resurrection

Table 7

Descriptive Statistics for Belief in Resurrection

	Frequency	Percent
Strongly Agree		
Male	7	7.7%
Female	54	59.3%
Moderately Agree		
Male	5	5.5%
Female	6	6.6%
Slightly Agree		
Male	2	2.2%
Female	5	5.5%
Slightly Disagree		
Male	3	3.3%
Female	1	1.1%
Moderately Disagree		
Male	1	1.1%
Female	3	3.3%

(table continues)

Table 7--Continued

	Frequency	Percent
Strongly Disagree		
Male	1	1.1%
Female	3	3.3%
Note for Table 7		
Total Frequency and Percent	91	100.0%
Number of Missing Cases: 6		

respectively. Thus a total of 86.8% of the sample expressed some degree of belief in the resurrection. Total percents for disagreement with resurrection belief: slight 4.4%, moderate 4.4%, and strong 4.4%.

Beck Hopelessness Scale Results

The results for the Beck Hopelessness Scale (BHS) show a mean of 39.90 and a standard deviation of 12.43 (See Table 8). Because this scale was modified to allow a greater range of scores, as was done by Mercier, Fawcett and Clark (unpublished, 1984), it was impossible to make direct comparisons with the norms of

the BHS. Results of Mercier, Fawcett and Clark (unpublished, 1984) were not available for comparison.

Table 8

Results of Beck Hopelessness Scale

	Observed	Beck's Norms*
Mean	39.90	3.98
Standard deviation	12.43	N/A
Median	38.50	3.70
Mode	25	1.00
Minimum	20	0
Maximum	77	11.40

Note. N = 97

* Beck's norms were estimated using formula (x-20)/5.

Based on extrapolation one could estimate that the mean of the present sample corresponds approximately to a mean of 4 on the original scale [M-20/5 = 39.90-20/5 = 19.9/5 = 3.98]. The highest score observed (77) would convert to a score of 11.4 on the original scale, a score which corresponds to moderate hopelessness [77-20/5 = 57/5 = 11.4]. Using Beck's norms would suggest

that this sample's level of hopelessness was primarily minimal to mild.

Table 9 reports confidence in belief concerning the resurrection and hopelessness.

Table 9

Resurrection Belief Confidence and Hopelessness

Response	Mean	Standard Deviation	Adjusted Beck	Cases
Strongly Agree	39.38	13.63	3.87	57
Moderately Agree	42.60	11.92	4.52	10
Slightly Agree	42.86	8.86	4.57	7
Slightly Disagree	40.00	17.66	5.00	4
Moderately Disagree	39.75	3.86	3.95	4
Strongly Disagree	38.00	14.11	3.60	3
Total	39.96	12.75	3.99	85

Spontaneously Reported Coping

Table 10 summarizes the participant's spontaneously reported methods of coping with his or her "most difficult bereavement stressor." Only coping behaviors reported 3 or more times were presented.

Table 10

Rank Order of Spontaneously Reported Coping Behaviors

Rank	Frequency	Coping Behavior
1	24	Keep busy
2	16	Spiritual (God, Prayer, Bible)
2	16	Talked with friend
3	12	Family
4	9	Keep working
5	8	Media (Books, Radio, TV)
6	6	Cry
7	5	Gardening
8	3	Walk
8	3	Volunteering
8	3	Reassuring self-statements
8	3	None

Note: N = 97

In all, 39 unique coping behaviors were identified. Many participants reported more than one coping behavior and thus there were a total of 134 coping behaviors reported by the 97 participants. Although

classification of these coping behaviors lacked the scientific rigor of interrater reliability, the categories give a general description of the authors findings.

Results of Judges' Classification of Coping

Spontaneous coping was based on the participant's response to the question asking for the participant's primary way of coping with the his or her most difficult bereavement stressor. Responses were transcribed and then rated by four judges who classified each coping response (as described in the methods section) into one of 7 possible coping options defined by the following numerically coded coping groups:

1 =	Activity:	Activity to Keep Busy
2 =	People:	Family, Friends, and Social
3 =	Spiritual:	Spiritual Coping
4 =	Combined:	Spiritual Coping combined with other options
5 =	Other:	Other. Not one of the above.
6 =	Mixed N-S:	Combination of non-spiritual coping methods
7 =	None:	No answer, no response.

Table 11 provides a summary of the judges' classification of the spontaneously reported way of coping. About a quarter of the sample used activity, a quarter reported mixed non-spiritual ways of coping, and the remainder reported a variety of coping strategies including 6% who reported spiritual and 8% who reported spiritual and other coping methods. Two of the coping options involve spiritual coping: Spiritual Coping and Combined Coping. Their percentages can be added resulting in a total of 14% of the participants who reported using some form of spiritual coping to deal with their most difficult bereavement stress. Table 11 shows the coping method with the highest frequency, as classified by the judges, was Activity tied with Mixed (26 each). The second most frequently reported coping behavior was Other (20), while People (9) ranked third. Combined Coping (8), defined by a combination of spiritual and other coping ranked fourth. Spiritual Coping (6) ranked fifth. However, by adding the two options expressly involving spiritual coping (Spiritual + Combined) the total becomes 14, thus "Spiritual + Combined" would then rank third, which more accurately

represents the prevalence of spiritual coping in this sample.

Table 11

Judges' Classification of Spontaneously Reported Coping

Coping Option	Frequency	Percent Valid	Percent	Cum Percent
Activity	26	26.8	26.8	26.8
People	9	9.3	9.3	36.1
Spiritual	6	6.2	6.2	42.3
Combined	8	8.2	8.2	50.5
Other	20	20.6	20.6	71.1
Mixed N-S	26	26.8	26.8	97.9
None	2	2.1	2.1	100.0
Total	97	100.0	100.0	

Results of the Hypotheses

Hypothesis One: Coping Behaviors and Hopelessness

The first hypothesis stated, "Coping behaviors as measured by the Ways Of Coping Questionnaire-Revised will not be significantly related to Beck Hopelessness scores." It was thought that participants who primarily coped with bereavement stress by utilizing Positive Reappraisal (PR), Planful Problem Solving (PS), or Spiritual Coping (S) would report less Hopelessness than participants who primarily utilized Distancing (D), or Escape-Avoidance. This Hypothesis was tested by with a Pearson correlation. The results of that correlation indicated that there was a significant negative correlation between Positive Reappraisal and Hopelessness ($r = -.278$; $p < .01$). There was also a significant negative correlation between Planful Problem Solving and Hopelessness ($r = -.274$; $p < .05$). The next strongest negative correlation with Hopelessness was Spiritual Coping but this was not significant at the .05 level. The results indicated that Coping by Distancing ($r = -.031$), Seeking Social Support ($r = .030$), or Escape-Avoidance

(.180) also were not significantly correlated with Hopelessness (see Table 12).

Table 12

Correlations of Coping Behaviors with Beck Hopelessness Scores

Coping Behavior	Rank	Correlation	Significance
Positive Reappraisal	1	-.278	.01
Planful Problem Solving	2	-.274	.05
Spiritual Coping	3	-.132	NS
Self-Controlling	4	-.118	NS
Confrontive Coping	5	-.092	NS
Accepting Responsibility	6	-.052	NS
Distancing	7	-.031	NS
Social Support	8	.030	NS
Escape-Avoidance	9	.180	NS

Hypothesis Two: Resurrection Beliefs and Hopelessness

The second hypothesis stated, "Bereaved spouses who report strong belief in resurrection will not differ significantly in Beck Hopelessness scores from bereaved spouses who do not hold such resurrection beliefs". The anticipated result was that there would actually be a difference, and that participants who believed in the resurrection would be less hopeless than participants who did not hold such beliefs. This hypothesis was tested by a one way analysis of variance. The results presented in Table 13 indicate that there were no significant differences in hopelessness scores based on belief or non-belief in resurrection.

Table 13

Analysis Of Variance For Resurrection Beliefs and Beck Hopelessness Scale

Source of Variance	Sum of Squares	DF	Mean Squares	F	Sig. of F
Main Effect	57.957	1	57.957	.354	.554
Explained	57.957	1	57.957	.354	.554
Residual	13600.937	83	163.867		
Total	13658.894	84	162.606		

Note. 97 cases were processed; 12 cases were missing.

Hypothesis Three: Resurrection Belief and Coping

The third hypothesis stated, "There will be no significant differences in reported coping behaviors, as measured by the Ways of Coping Questionnaire-Revised, among bereaved spouses who report strong belief in resurrection and those who do not hold such beliefs." This hypothesis was tested by a discriminant analysis. Results of that analysis are presented in Table 14. The anticipated result was that differences in coping behaviors would be evident. It was thought

that spouses who reported a strong belief in the resurrection would be more likely to use Spiritual Coping to manage bereavement stress than would spouses who do not hold such resurrection beliefs. It was also thought that participants who believed in the resurrection might use less Escape-Avoidance than participants who did not hold such beliefs.

The analysis was based on two groups. Group 1 was comprised of 50 individuals who reported strong belief in the resurrection. Group 2 was comprised of 27 individuals whose beliefs ranged from moderate belief in the resurrection to strong disagreement with belief in the resurrection. Table 14 shows the group means for each of the coping behaviors as defined by the factors associated with the WOCQ-R and the Spiritual Coping options provided in this study. Ninety-seven (unweighted) cases were processed. Twenty cases were excluded from the analysis for the following reasons: missing group codes (n=4), missing one or more variables (n=12), and missing the group code and a one or more variables (n=4). The 77 remaining cases were used in the analysis.

Table 14

Resurrection Beliefs and Coping Behavior

	Ways of Coping				
GROUP	CC	D	SC	SS	AR
1 Mean	4.70	5.54	9.20	8.08	2.26
2 Mean	4.74	5.22	8.89	5.78	1.85
Total Mean	4.71	5.43	9.09	7.27	2.12
1 SD	2.27	3.24	4.32	4.19	2.36
2 SD	3.28	3.60	3.25	4.20	1.97
Total SD	3.25	3.35	3.96	4.20	2.23
GROUP	EA	PS	PR	S	
1 Mean	4.88	7.94	6.10	9.34	
2 Mean	5.56	7.22	4.04	4.30	
Total Mean	5.12	7.69	5.38	7.57	
1 SD	4.68	4.13	3.99	5.84	
2 SD	4.12	3.59	2.68	4.51	
Total SD	4.48	3.94	3.70	5.90	

Note. N = 77. Group 1 = Strongly believes in resurrection. Group 2 = All other resurrection beliefs ranging from strongly disagree to moderately agree.

(table continues)

Table 14--Continued

Total = Total (combined groups 1+2) CC = Confrontive Coping, D = Distancing, SC = Self-Controlling, SS = Seeking Social Support, AR = Accepting Responsibility, EA = Escape-Avoidance, PS = Planful Problem Solving, PR = Positive Reappraisal, S = Spiritual

To investigate if resurrection beliefs were predictive of coping behaviors it was necessary to classify resurrection belief groups. Belief groups were determined by the participant's responses to the demographic item which provided an opportunity to indicate the extent of agreement to the following statement: "I believe that people who have been spiritually reborn through faith in Jesus Christ will be resurrected from the dead to live eternally with God." Each participant selected the option which was most descriptive of himself or herself. There were 61 participants who strongly agreed (67%), moderate agreement - 11 (12.1%), slight agreement - 7 (7.7%), slight disagreement - 4 (4.4%), moderate disagreement - 4 (4.4%), and strong disagreement - 4 (4.4%). Altogether 86.8% of the participants expressed some

belief in the resurrection while 13.2% of participants expressed disagreement with belief in resurrection. Because confident belief in the resurrection is central to the Christian faith (I Cor 15:3, 14) the analysis of coping behaviors was done by comparing individuals who expressed a strong belief in the resurrection (67%), with all other participants including those who were in moderate or slight agreement with belief in the resurrection, and participants who indicated that they did not believe in the resurrection (33%). Table 15 shows the results of the discriminant analysis which explored the ability to correctly predict resurrection beliefs based on reported coping behaviors.

Table 15

Classification of Participants by Function of Resurrection Beliefs

Group	Predicted Group Membership		
	N	GRP 1	GRP 2
1: Resurrection Strong Belief	56	38	18
		67.9%	32.1%
2: No Resurrection	28	06	22
		21.4%	78.6%
3: Ungrouped Cases	06	03	03
		50.0%	50.0%
Percent of total cases correctly classified			71.43%

Note. 97 cases were processed; 7 cases were excluded due to missing variables. Data based on 90 cases.

The discriminant analysis produced a standardized canonical discriminant function coefficient of R = .4747, $p < .001$ (See Table 16).

Table 16

Unstandardized Canonical Discriminant Function Coefficients

Coping Behavior		Function
SS	Seeking Social Support	0.0094
AR	Accepting Responsibility	0.1846
EA	Escape-Avoidance	-0.1353
S	Spiritual	0.1450
K	(Constant)	-1.4827

The formula for the canonical discriminant function is: Resurrection Belief Group = -1.48 + SS(.0094) + AR(.1846) -EA(.1353) + S(.145). Group 1 (Strong Belief) = 0.3911, Group 2 (Other than Strong belief) = -0.7243. The Canonical Correlation was 0.4747 (*p*. < .0009).

Four basic assumptions must be met to compute a valid discriminant analysis:

1. No participant can be a member of more than one group.

2. Equality of group covariance matrices.
3. Multivariate normality.
4. No predictor variable may be a linear combination of other discriminating variables.

The first assumption was met in that by their self-report participants indicated either strong belief in the resurrection or they did not. (One can not believe strongly in the resurrection and not believe in the resurrection at the same time.) In this respect the assumption was met as the two groups were mutually exclusive.

The second assumption states that the variance of predictor variables must be the same within both criterion groups. This is expressed in terms of a covariance matrix (see Table 17). SPSS statistical package utilizes Box's M to test for equality of covariance matrices. In this analysis, Box's M = 10.68, (approximate $\underline{F}$ (10, 134228) = .997, $\underline{p}$ = .44), thus the covariance matrices of the two groups were similar. This suggests that this assumption was not violated.

Table 17

Tests for the Equality of Covariance Matrices

Box's M	Approx. F	Degrees of Freedom		Sig.
10.68	0.997	10	13422.8	.44

Note. N = 90.

The third assumption is multivariate normality. Tests for this model assumption are less obvious. Therefore it has been suggested that the distribution of each of the variables be done individually because if the variables are jointly distributed normally as a multivariate, it follows that each variable is individually distributed normally (Norusis, 1988). Departures from normality, unless extreme, do not seriously affect results (Noruris, 1988, p. 248-249). For the current research, normality was not tested.

The fourth assumption requires that predictor variable are not in linear combination with other discriminating variables due to problems with redundancy. Such multicollinearity would result in a variable that would not contribute any new information to the equation, and which may actually dilute the

discriminatory ability of the function. To check for this a pooled within-group correlation matrix was examined.

Table 18

Within-Group Correlation Matrix Of Coping Behaviors

Scale	1	2	3	4	5	6	7	8	9
1. Confrontive Coping		.34	.39	.49	.54	.59	.46	.47	.12
2. Distancing			.51	.37	.39	.49	.27	.32	.14
3. Self-Controlling				.35	.32	.39	.57	.47	.21
4. Seeking Social Support					.37	.45	.32	.46	.31
5. Accepting Responsibility						.57	.20	.26	.05
6. Escape-Avoidance							.16	.27	.08
7. Planful Problem Solving								.69	.31
8. Positive Reappraisal									.52
9. Spiritual Coping									

The intercorrelations among predictor variables were all < .60, except for the correlation of Planful Problem Solving and Positive Reappraisal was .69. Tabachnick and Fidell (1989) suggested there should be

concern when $r \geq .70$. Thus, multicollinearity is not considered to be a problem with this data.

In summary, it appears that three of the four assumptions are met, and only a mild degree of concern is raised regarding the assumption of multivariate normality. Norusis (1988, p. 248-249) suggests that departures from normality are not an important concern.

Hypothesis Four: Spontaneously Reported Coping

The fourth hypothesis stated, "There will be no significant difference in Beck Hopelessness Scores among bereaved spouses who spontaneously report spiritual beliefs or behavior as their primary method of coping with bereavement and those who spontaneously reported Non-Spiritual Coping methods as their primary way of coping with bereavement stress." It was thought that participants who primarily used Spiritual Coping behaviors to cope with bereavement stress would be less hopeless than participants who primarily coped with bereavement stress using Non-Spiritual Coping.

A one way analysis of variance was used to analyze whether participants who Spontaneously Reported Spiritual Coping as their primary way of coping with bereavement stress differ in level of hopelessness when

compared with bereaved spouses who reported non-spiritual ways of coping. There was no significant difference in Hopelessness scores found between the two groups, (F .7184) = .718, p = .636).

Table 19

Coping Behavior by Group and Hopelessness

Cope Behavior	Count	Mean	Standard Deviation	Error	95% Confidence
Activity	26	39.577	12.959	2.452	34.343 - 44.811
People	08	44.250	13.318	4.709	33.116 - 55.384
Spiritual	05	46.200	17.936	8.021	23.930 - 68.470
Combined	07	35.000	6.429	2.886	29.054 - 40.946
Other	15	36.933	11.177	2.886	30.744 - 43.123

(table continues)

Table 19--Continued

Cope Behavior	Count	Mean	Standard Deviation	Error	95% Confidence
Mixed N-S	26	40.654	12.856	2.521	35.461 - 45.847
None	01	44.000			
Total	88	39.932	12.475	1.330	37.289 - 42.575

Groups	MIN	MAX
1 = Activity	21	67
2 = People	27	66
3 = Spiritual	27	67
4 = Combined	25	44
5 = Other	20	60
6 = Mixed N-S	23	77
7 = None	44	44
Total	20	77

Note. N = 88.

Summary of Results

Participants included 75 females with a mean age of 67.4 years (SD 11.8 years) and 21 males with a mean age of 60.5 years (SD 15.0 years). The mean time of bereavement was 7.6 months (SD 4.3 months). The majority (86.8%) of these participants reported some degree of belief in the resurrection, which included 67% of the participants who reported strong belief in the resurrection. In each group, mild, moderate, or strong disagreement concerning belief in the resurrection represented 4.4% of the participants, thus totaling 13.2% of the sample.

The extended range Beck Hopelessness Scale resulted in scores which ranged from 20 to 77, with a mean of 39.9 and a standard deviation of 12.43. It was estimated (using mathematical conversion and Beck's norms) that this sample's level of hopelessness was primarily minimal to mild.

A total of 134 ways of coping with bereavement stress were spontaneously reported by 97 participants. Responses were transcribed and then rated by four judges who found that approximately one quarter of the participants used activity to keep busy as their primary way of coping with their most difficult

bereavement stressor. Another quarter reported mixed non-spiritual ways of coping. Spiritual Coping was reported by 14% of the participants (Spiritual + Combined). Approximately 20% of coping was classified as "Other", about 9% was classified as "People", and about 2% did not answer the question.

The investigation of the relationship between Coping Behaviors and Hopelessness revealed a negative correlation between Positive Reappraisal and Hopelessness. There was also a negative correlation between Planful Problem Solving and Hopelessness.

The investigation of Resurrection Beliefs and Hopelessness revealed that there were no significant differences in hopelessness scores based on belief or non-belief in the resurrection.

The investigation of Resurrection Belief and Coping Behavior revealed that four coping behaviors were predictive of strong belief in the resurrection. Seeking Social Support, Accepting Responsibility, and Spiritual Coping were positive predictors; Escape-Avoidance was a negative predictor. By knowing an individual's coping behaviors and by applying the canonical discriminant function, presented with Table 16, one can correctly predict strong belief in the

resurrection in 71% of bereaved spouses. Belief in Resurrection accounted for 22.5% of the variance in coping behaviors. Thus, there was a significant relationship between resurrection belief and coping behaviors.

The investigation of Spontaneously Reported Ways of Coping and Hopelessness revealed that there were no significant difference in hopelessness scores based on reported spiritual or Non-Spiritual Coping.

CHAPTER 4

DISCUSSION

The relationship between coping behaviors and hopelessness was examined among bereaved spouses of hospice patients. The relationship of resurrection beliefs and hopelessness, and the relationship of resurrection beliefs and the selection of coping behaviors were also examined. Lastly we explored whether there was a significant difference in hopelessness among those who spontaneously reported Spiritual Coping and those who spontaneously reported Non-Spiritual Coping. The psychological and Biblical literature which provided the background for this study was presented in chapter 1. The methods used to collect data were presented in chapter 2. The results of the study were presented in chapter 3, and now the

empirical results presented in chapter 3 shall be discussed.

This discussion is presented in four sections: (a) limitations of this research, (b) interpretation and implications of the results, (c) recommendations for future research, and (d) conclusions.

Limitations Of This Research

All research has limitations. Some limitations are inherent to particular methodologies while other limitations arise from flawed decision making. Research limitations are presented so the reader can refrain from making confident conclusions based on erroneous evidence and for the benefit of future research developments. The current study had several weaknesses that merit discussion. The discussion has been organized according to four types of weakness: (a) weaknesses inherent in surveys, (b) weaknesses relevant to instruments, (c) weaknesses relevant to statistical analysis, and (d) possible errors in underlying assumptions.

Weaknesses Inherent in Surveys

It is likely that the present study was limited by self-selection bias regarding hopelessness and spiritual beliefs. The average person doesn't respond to requests to participate in a survey and those who actively volunteer may not be representative of the population (Mitchell & Jolley, 1988, p. 304). In the current study 300 people were contacted to participate. There were 100 people who actually completed surveys and 3 surveys were excluded for the reasons explained in Chapter 2. The 1/3 who responded may have been more hopeful and higher functioning that those who did not respond. Generally speaking, completion of the current survey required a fairly high investment of thought which would tend to exclude individuals who have low motivation, low energy, or impaired concentration. Such symptoms are often associated with depression and hopelessness. In addition, individuals who feel hopeless are likely to conclude that such research is pointless and would not be inclined to respond. Such self-selection bias would contribute to an artificially high number of individuals who were more hopeful, reducing the range of hopelessness scores, resulting in

less certainty concerning conclusions about those who were not equitably represented.

In addition to a lack of participants who were hopeless, few participants mildly, moderately, or strongly disagreed with belief in the resurrection. This may have resulted from a false perception that the research was only for individuals who held traditional Christian beliefs. Religious beliefs have been considered by many to be a private matter, a taboo topic. Perhaps spiritual beliefs are especially taboo among people who feel their views are in a minority and/or that others are attempting to change them. Gallup polls (1935-1985) indicated that 95% of the general public reported a belief in God. Although belief in God is not the same as belief in the resurrection it does suggest the possibility of bias in that direction. Another possibility is that participants who disagree with belief in the resurrection were simply not interested in responding to a survey which provided an opportunity to express afterlife beliefs. Perhaps some individuals were concerned about misunderstanding spiritual terminology or concerned that expressing any particular belief, in a restricted space, would not satisfactorily represent

his or her point of view. The effects described concerning selection bias pertaining to hopelessness may also apply to having only a few participants who did not believe in the resurrection.

Weaknesses Relevant to Instruments

There were several concerns related to the instruments used in data collection. The modifications used to expand the range of the Beck Hopelessness Scale provided results which cannot be directly compared with standardized norms. However, the estimated range of hopelessness was primarily minimal to mild, thus making it difficult to draw meaningful conclusions concerning individuals experiencing greater degrees of hopelessness.

The demographic questionnaire had to be modified mid way-into the research to satisfy one of the hospice programs (as described in chapter 2). It is likely that there were no significant differences between the two forms, however, the differences in the questionnaire may have prompted somewhat different responses. Unfortunately data was not processed in such a way as to provide a compairson.

The participants' spontaneously reported coping behaviors involved some violations of the instructions. Many participants listed several "primary way(s)" of coping with their most difficult bereavement stressor. Although such information reflects the reality that people use multiple coping methods to deal with a given stressor, the additional responses complicated the coding and judging process. The fact that judges classified coping responses into coded categories indicates a compression of raw data. Such categorization results in loss of details and perhaps meaningful distinctions. Though the interjudge reliability was good, something is always lost in the conversion from raw data to classified groups.

Weaknesses Relevant to Statistical Analysis

Weaknesses presented in the discussion of "weaknesses relevant to instruments" also have relevance concerning statistical analysis. Some response alternatives were represented by a small number of participants, thus increasing chances of a biased statistical analysis. The lack of participants reporting high levels of hopelessness, and the small number of participants reporting strong disbelief in

the resurrection, made it difficult to draw meaningful conclusions concerning what hopeless individuals do to cope with bereavement stress, and in what ways, if any, disbelief in the resurrection is related to level of hopelessness.

The discussion concerning the classification of coping responses is also relevant concerning statistical analysis. Coded categories compress raw data, thus resulting in loss of details and perhaps loss of meaningful distinctions.

Possible Errors in Underlying Assumptions

A key assumption for this research came from an interpretation of the Apostle Paul's statement, "But we do not want you to be uninformed brethren about those who are asleep, that you may not grieve, as do the rest who have no hope" (I Thessalonians 4:13, NASB). In chapter 1 it was suggested that people who are aware of and believe in the resurrection will grieve differently than individuals who have no hope in the resurrection. This was supported by the current research which demonstrated differences in coping behaviors based on resurrection belief. However, individuals who "have no hope" didn't participate in this research, thus it was

impossible to draw fair conclusions concerning hopelessness and resurrection belief.

Upon further consideration of I Thessalonians 4:13 the observation was made that the Apostle Paul was talking about people who were "asleep". The statement referred to all who are "asleep" which included people who were dead for a long time. There may have been an error based on assumptions concerning time of bereavement. It is likely that Paul was addressing a more enduring concern about eternal hope rather than the sudden feeling of hopelessness more often associated with the initial shock of recent bereavement. It may be that Paul was primarily referring to deaths that occurred a year or more ago, whereas the mean time of bereavement in this study was 7.6 months. Perhaps the original time assumption based on I Thessalonians 4:13 doesn't fit the 1-16 months of bereavement window of this study. Perhaps resurrection beliefs facilitate long term bereavement recovery after 2 years or more.

Another interpretation may exist if a distinction is made between feeling hopeless and being positionally hopeless according to Biblical standards (i.e. those who will not experience eternal life with God). An

individual who positionally lacks eternal hope may not feel hopeless grief during bereavement. It is quite possible that the individual has another source of hope in which he or she is confident. The findings of this study seem to support the finding that people who are confident in their beliefs are less hopeless than those who are less confident in their beliefs, though there were only three who strongly disagreed with belief in the resurrection (see Table 9).

Other possible errors involved assumptions about hospice programs. It was assumed that there would be a wide range of hope/hopelessness and variety of resurrection beliefs. Herth (1990) indicated that bereaved spouses who were involved with hospice had significantly higher levels of hope and grief resolution than participants whose spouses died in a hospital or nursing home. Nonetheless, it was assumed there would still be measurable differences among the bereaved spouses of hospice patients. Results indicated that there were no participants who were severely hopeless. The low degree of hopelessness found in this research is consistent with the finding that involvement in hospice significantly reduces hopelessness among the bereaved (Herth, 1990).

Another consideration relevant to hospice is the nature of death and the roll of anticipatory grief. As indicated in chapter 1, "In recent years dying has increasingly become the experience of the elderly and is generally associated with long-term diseases." That finding is consistent with the current research where 85% of the participant's reported that their spouses died of a lingering illness. Data was not collected concerning length of illness because of the difficult nature of defining when an illness began, especially when one illness leads to another. So it is not known how long participants were coping with aspects relevant to caring for an ill spouse. Although cause of death has uncertain effects concerning how one will cope with grief, research indicates that family members who provide care for a chronically ill relative experience deterioration in a number of domains (also presented in chapter 1, Bass & Bowman, 1990). It was assumed that the possibility for hopelessness would be higher following the death of one's spouse. It is possible that levels of hopelessness were higher among spouses during the time of illness rather than after the death. The death of the spouse may in fact promote new hope once the suffering has ended and new opportunities are

available to reinvest in life. The relief of suffering was cited as a reason to hope, it is likely that the relief of suffering also promotes hope.

Anticipatory grief can be observed when a patient lingers for a long period. Relatives may anticipate the death so much that in their minds, they buried the individual before he or she actually died. They go through the usual grief process before death (Bachmann, 1966, p. 23). The people close to the dying individual anticipate all their impending losses and begin the separation process of anticipatory grief. They begin to recognize the defeat and loss they feel, and the strain of additional role obligations. Because of this period of anticipation, when death finally comes, loved ones may display less public grief, and may find themselves expected to show emotions they have already worked through. Survivors may feel guilt and shame as a reaction to their own less-than-expected feelings, and the disapproval of others (Kuenning, 1987, p. 202). It may be that the initial intensity of anticipatory grief influences coping needs more grief coping subsequent to the loss. Thus research may have discovered a wider range of hopelessness among spouses if surveys were completed prior to the actual death.

Despite these limitations, there were significant findings which are discussed in the following section. The following section reviews each hypothesis, interprets statistical results, and discusses implications of the results relevant to Chapter 1 and counseling interventions for the bereaved.

Interpretation and Implication of the Results

Discussion of Hypothesis One: Coping Behavior and Hopelessness

Hypothesis one stated: "Coping behaviors as measured by the Ways Of Coping Questionnaire-Revised will not be significantly related to Beck Hopelessness scores." Each of the eight factors of the Ways Of Coping Questionnaire-Revised (WOCQ-R) were investigated. The factors which were used as coping scales in this study were: Confrontive Coping (CC), Distancing (D), Self-Controlling (SC), Seeking Social Support (SS), Accepting Responsibility (AR), Escape-Avoidance (EA), Planful Problem Solving (PP), and Positive Reappraisal (PR). Spiritual Coping (S) was also included in this evaluation of coping behaviors and hopelessness. To review the factor descriptions

refer to Table 2. A Pearson correlation revealed that two coping behaviors were in fact negatively correlated with Hopelessness. Positive Reappraisal had the strongest negative correlation with Hopelessness ($r = -.278$, $p < .01$). Planful Problem Solving also had a significant negative correlation with Hopelessness ($r = -.274$, $p < .05$). Thus the null hypotheses was rejected as applied to Positive Reappraisal and Planful Problem Solving. Results for the remaining coping factors were not significant. Limitations in the range of hopelessness may have resulted in an underestimate of the relationships between coping and hopelessness.

The finding that Positive Reappraisal was negatively correlated with Hopelessness is consistent with the idea that appraisal is a key component in coping with stress (Lazarus and Folkman, 1984). Folkman and Lazarus described Positive Reappraisal as efforts to create positive meaning by focusing on personal growth including a religious dimension (Folkman & Lazarus, 1988).

Since correlations do not prove causal relationships two key explanations are presented at this time. First, it may be that when bereaved spouses begin to focus on personal growth they begin to feel

less hopeless. A second possibility is that bereaved spouses who already feel less hopeless are more able to reappraise stressors in a positive light.

One implication of the first option is that by helping a bereaved individual reappraise stressors in light of personal growth and or religious faith the counselor may facilitate a reduction in feelings of hopelessness. This seems consistent with Frankl's (1963) writing on man's search for meaning where he wrote, "There is nothing in the world, I venture to say, that would so effectively help one to survive even the worst conditions, as the knowledge that there is meaning in one's life" (p.164). The connection with Frankl's statement is that if one's life has meaning then stressors also have meaning and the meaning for any particular stressor may well be for personal growth.

The relationship of loss and personal growth was addressed by Joesten (1987):

> The process we call grief is the bridge between loss and growth. One hopes that through that process what was negative will ultimately yield some potential promise. I discourage even hinting that "something good will come out of this." Only

> time and events will tell that for certain. But it is important for the chaplain to believe that loss and growth do go hand in hand, and that little growth ever occurs without some accompanying loss or sacrifice.... Unlike physical pain, someone in grief must be encouraged to endure the pain, to live with it. It cannot be covered or hidden if it is to be extinguished (p. 144-45).... How then shall a chaplain help someone who has experienced the sadness and devastation of the death of a loved one? How can the negatives of this loss be converted into an opportunity for growth? The chaplain helps by embodying someone to hope with them, to believe in them, and to be honest with them. (p.148)

The Bible is not silent concerning the trials of life, personal growth and meaning. The Bible teaches,

> Consider it pure joy, my brothers, whenever you face trials of many kinds, because you know that the testing of your faith develops perseverance. Perseverance must finish its work so that you may be mature and complete, not lacking in anything. If any of you lacks wisdom, he should ask God, who gives generously to all without finding fault, and

> it will be given to him. But when he asks, he must believe and not doubt, because he who doubts is like a wave of the sea, blown and tossed by the wind. (James 1:2-6, NIV)

James 1:1-6 applies to positive reappraisal and personal growth in this respect: The individual is encouraged to consider (reappraise) trials (stressors) as a developer of perseverance, so that he or she many be mature (personal growth). Also note the relationship of confident expectation to receiving wisdom from God. This too may serve as positive reappraisal for individuals who "strongly believe" the promises of God. They are able to trust that God generously gives wisdom to help them persevere to maturity.

The counseling implication is that one key for unlocking a doorway of hope is provided by inviting the bereaved to appraise how her bereavement stress has contributed to her personal growth. If the person is able to see how she has developed new strengths or effectively utilized or improved upon old coping behaviors, she may discover that such coping behaviors are useful in other areas of personal growth. Success breeds success.

The second alternative suggests a two part counseling intervention. Part 1, the counselor helps the bereaved individual identify things that have contributed to his or her feelings of hope. After understanding the individual's various sources of hope the counselor (part 2) builds on the individual's beliefs and behaviors which promote hope and thereby enhances the individual's ability to positively reappraise stressful situations. Such an approach is consistent with brief therapies which utilize the client's strengths and values to build on success (where they exist) as the means to achieving a desired outcome (O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992). The following points are paraphrased to identify important aspects of Erickson's utilization approach (Zeig, 1985 p. 38-39):

1. Identify unaccessed strengths in the client.
2. Identify the client's values and preferences.
3. Develop the resource by utilizing the clients values.
4. Connect the developed resources to the goal. Move in small steps, accessing trust, rapport and motivation. Clients learn best by doing.

5. Any behavior, even resistance, can be utilized therapeutically.
6. Drama can enhance responsiveness.
7. Seeding ideas prior to presenting them primes responsive behavior.
8. Timing is crucial. Therapy involves pacing, disrupting, and pattering. Resistance often results from inadequate attention to these processes.
9. The therapist and patient must have an expectant attitude.

The second significant finding was that widows and widowers reported less hopelessness when they cope with bereavement stress by Planful Problem Solving. Folkman and Lazarus described Planful Problem Solving as deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem (Folkman & Lazarus, 1988). Since correlations do not prove causal relationships two ideas of potential causation are presented (of course this relationship could be due to some unknown variable). If there were a causal relation it could be in either direction. Looking at it from one perspective, individuals who are already hopeful are

more likely to be willing and able to explore and analyze coping options than those who are hopeless. The other perspective is that people who are already confidently generating solutions and developing effective ways of coping are more likely to become hopeful than individuals who have not been effectively analyzing satisfying coping options.

The finding that Planful Problem Solving was negatively correlated with Hopelessness is consistent with the idea that hope believes change is possible. Logic suggests that if a person deliberately invests time and energy to analyze and solve a problem, that person believes that a desired outcome is possible. Furthermore, planful problem solvers do not feel helpless, but rather they expect that their efforts will be effective.

Implications for grief therapy include: (a) honoring the client's ability to analyze and solve problems, and (b) helping the client discover and develop new problem solving resources relevant to specific needs. Some potential interventions are presented in the following paragraphs.

Honoring the individual's ability to analyze and solve problems may involve an exploration of how the

bereaved coped with past stressors and then developing the person's belief that his or her problem solving skills will be useful concerning current needs. Guided imagery may be useful for such a task. If the client is unable to imagine the solution to a problem perhaps they can imagine and articulate how someone they admire would cope with such a stressor (this is consistent with the one-step removed approach of solution focused therapy). Another intervention may be to have the bereaved role play, asking a family member or friend for "tools" they consider necessary for coping with a particular stressor. The tools provide clues to the person's ability to analyze what is needed to reach the goal, and the role play is a rehearsal for taking action.

Another option may include interventions which provide an opportunity for the bereaved individual to demonstrate her ability to break down a problem into manageable steps. By breaking the problem into manageable steps, the person discovers that each of the steps is less overwhelming than the whole and thereby motivation is enhanced and the potential for success increases. With each success momentum builds, thus overcoming the inertia of hopelessness.

The relationship of Planful Problem Solving and Hopelessness suggests that it may be useful to invite clients to consider and discuss several areas of personal competence. Encourage the individual to brain storm about how such personal attributes relate to coping with the current situation.

Some hopeless individuals may be served by paradoxical interventions which incorporate cognitive dissonance. For example, the counselor may work with the bereaved individual to imagine a state of complete and absolute hopelessness. The individual would explore how behaving in ways that are even more hopeless can accomplish certain goals. By discovering just how effective being hopeless is (for particular goals) the individual is then asked to recognize how well he perceived and analyzed the situation to achieve the desired negative outcome. If the individual discovers that even in his current hopelessness he was able, and in fact actually used analytical skills to effectively solve/avoid/defend against some problem, then logic suggests that he is not as helpless or devoid of the ability to cope as he may have imagined. By employing his analytical problem solving skills, which he identified while exploring how hopeless

behavior was providing some personal benefit, a cognitive dissonance is created. How can one who is so successful at developing imaginative ways to be hopeless have no analytical ability for attaining other important (hopeful) goals?

Spiritual Coping had the third greatest negative correlation with Hopelessness, although it was not statically significant. The first conclusion is that this data does not support the hypothesis that spiritual coping is valuable. However, it is possible that spiritual resources may facilitate Positive Reappraisal or Planful Problem Solving. For example the Bible teaches that, in all things God works for the good of those who love Him, who have been called according to his purpose (Romans 8:28). This verse comes to mind because it is almost automatically quoted by some Christians in times of stress. Many pages of scripture could be quoted as examples of statements that encourage Christians to positively reframe their perspectives in light of God's attributes and promises but the point is, positive reframing is not necessarily exclusive of spiritual coping. Furthermore, it is possible that Planful Problem Solving may involve

options that are guided by spiritual values, or involve some spiritual resources.

The finding that Spiritual Coping was not significantly related to Hopelessness contrasts with Koenig, Moberg, and Kvale (1988) who found that, among adults age 75 and over, religious activities and attitudes explained more of the variance in well-being than any other variable except for health. It would seem reasonable that well-being would be related to hopefulness. The findings of the current study support previous findings that spiritual coping is consistently identified as a preferred coping method. This consistent popularity implies that participants are receiving some benefit from spiritual coping.

In the current study Escape-Avoidance was not related with Hopelessness. Folkman and Lazarus describe Escape-Avoidance as wishful thinking and behavioral efforts to escape or avoid the problem. Items on this scale contrast with those on the Distancing scale, described as cognitive efforts to detach oneself and to minimize the significance of the situation (Folkman & Lazarus, 1988). Chapter 1 introduced the controversy concerning denial as a coping option. Recall that "maladaptive" coping skills

such as denial can be an effective and life-saving coping skill (Gentry, Foster, & Harvey, 1972). Yet others reported that denial maintains stressors and delays grief resolution (Worden, 1982, p. 11-15). Folkman and Lazarus' definition of Distancing is more descriptive of the concept of denial than is their description of Escape-Avoidance. The statistical evidence of this study failed to demonstrate a relationship between Escape-Avoidance and Hopelessness. Therefore the controversy concerning the relationship of escape-avoidance and hopelessness remains unresolved. Escape-avoidance continues to be a very popular coping behavior and has been presented again in the discussion of hypotheses four.

The five remaining factors relevant to the Ways of Coping Questionnaire-Revised included: Confrontive Coping, Distancing, Self-Controlling, Seeking Social Support, and Accepting Responsibility. Those factors also were not significantly correlated with Hopelessness. Thus among bereaved spouses, no relationship was evident between such coping behaviors and hopelessness. Though is it possible to incorrectly retain a null hypothesis, for the theoretical reasons discussed that doesn't seem to be the case here. Such

findings present no clear direction for grief therapists with respect to reducing feelings of hopelessness.

Discussion of Hypothesis Two: Resurrection Beliefs and Hopelessness

Hypothesis two stated: "Bereaved spouses who report belief in resurrection will not differ in levels of Hopelessness from persons who do not hold such beliefs." The one way analysis of variance indicated that there was no significant difference in Hopelessness scores among the two groups of participants. The lack of significant difference does not appear to support the Apostle Paul's statement concerning grief, resurrection and hopelessness, "But we do not want you to be uninformed brethren about those who are asleep, that you may not grieve, as do the rest who have no hope" (I Thessalonians 4:13, NASB). Recall as stated in chapter 1, "The implication is that when a person is aware of and believes in the resurrection, such a person's grief will be different from the grief of others who have no hope in the resurrection." There are several possible explanations to address the lack of significant difference. A

number of these explanations were presented in the discussions concerning weakness in surveys and weaknesses in underlying assumptions and included: (a) limited variation in sample on resurrection beliefs and hopelessness, (b) the self-selection bias of participants characteristic of voluntary surveys, (c) the involvement of hospice in the lives of these participants may have promoted hope, (d) hospice deaths may not be as hopeless as other deaths, (e) the grief time frame of subjects did not capture the focus of I Thessalonians 4:13, and (f) the role of long term illness, anticipatory grief may have influenced Hopelessness scores.

The explanations addressing the lack of significant difference seem not only likely but probable in reference to the finding that confidence of belief or certainty of faith appears to promote or maintain hopefulness. Herth (1989) found that participants who indicated a strong religious faith had significantly (p = .05) higher mean scores on the Herth Hope Scale and the Jalowiec Coping Scale than the mean scores of the other four groups: weak, unsure, lost, or without faith. Haun (1977) showed that adjustment problems were greatest among the bereaved when

religious orientation was weak. Those with strong religious commitments apparently cope best with their loss. Others observed that "ideas of the resurrection and afterlife did not seem to reduce the initial intensity of grief... but did seem to help sustain morale once grief began subsiding" (Glick, Weiss, & Parkes, 1974, p. 133).

Another possibility is that individuals who are participating in hospice are less hopeless than the general population. Herth (1990) found that the mean score on hope, grief resolution, and the confrontive, optimistic, palliative, supportive, and self-reliant coping styles were significantly higher for participants whose spouses died in a hospice setting than from those who died in a hospital or nursing home.

Upon further consideration of I Thessalonians 4:13 the observation was made that Paul said, "...that you may not grieve as do the rest who have no hope." The difference Paul desired was a difference in response to grief. Paul's statement is more directly related to the third hypothesis of this study where it was observed that differences in resurrection belief were related to significant differences in reported selection of ways of coping. The conclusion is that

coping differently is equivalent to grieving differently.

Nevertheless, due to lack of significant findings in the current study it would be inappropriate to make counseling recommendations concerning hopelessness based on the current data.

Discussion of Hypothesis Three: Resurrection Belief and Coping Behavior

Hypothesis three stated: "Bereaved spouses who report strong belief in the resurrection will not differ in their use of coping behaviors from bereaved spouses who do not hold such resurrection beliefs." A discriminant analysis was used to explore whether different coping behaviors were used by the aforementioned groups. The anticipated result was that there would be both similarities and differences in coping behaviors. It was thought that participants who reported a strong belief in the resurrection would be more likely to use Spiritual Coping than participants who do not hold such resurrection beliefs.

Results from the discriminant analysis indicated that participants who reported belief in the resurrection more often use Seeking Social Support,

Accepting Responsibility, and Spiritual Coping as coping behaviors and less often coped by Escape-Avoidance than the participants who reported less than strong belief in a resurrection. Generally speaking, such coping behaviors are considered to reflect healthy patterns of coping. Escape-avoidance is generally seen as behavior that prolongs grief resolution. The short term benefit one gains from denial, escape, or avoidance is generally off-set by the delay of the tasks of mourning. Such coping behaviors have been viewed as healthy when dealing with the initial news of terminal illness, but such responses only offer temporary value. The coping options of Seeking Social Support, Accepting Responsibility, and Spiritual Coping are consistent with behaviors that promote acceptance of the loss, experiencing the pain of grief, adjusting to an environment in which the deceased is missing, withdrawal of emotional energy from the deceased and investing in other relationships (Worden, 1982).

The canonical correlation coefficient was .4747, which accounts for 22.5% of the variance in coping. About 71% of participants were correctly classified. These findings indicate that those with strong belief in the resurrection use different coping strategies

than the participants who were less confident about the resurrection or participants who expressed no belief at all in the resurrection.

One counseling implication relevant to the differences in coping strategies is simply to remember that an individual's spiritual beliefs are related to his or her choice of coping behaviors. If a client reports a strong belief in the resurrection it is quite likely that he or she will be involved with and receptive to interventions involving seeking social support, accepting responsibility, and spiritual coping. Unfortunately the results of this research did not demonstrate that any particular combination of coping behaviors or resurrection beliefs was related to lower levels of hopelessness. Based on the present data, it would be premature to suggest that the presence or absence of any particular coping behavior significantly increases or decreases hopelessness. Thus it is unclear whether these differences in coping were related to the effectiveness of the participant's coping. Nonetheless, those who strongly believed in the resurrection used different coping styles than those who did not. The Apostle Paul's statement, "...do not grieve as those who have no hope (I

Thessalonians 4:13) was supported by the finding that people who expressed strong belief in the resurrection reported significantly different choices of coping options when compared with participants who did not hold such beliefs.

Discussion of Hypothesis Four: Spontaneously Reported Ways of Coping with Bereavement

Hypothesis four stated: "The Hopelessness scores of bereaved spouses who spontaneously report spiritual beliefs and behaviors as their primary method of coping with bereavement will not significantly differ from the Hopelessness scores of bereaved spouses who spontaneously reported Non-Spiritual Coping methods as their primary way of dealing with bereavement stress." A one way analysis of variance revealed no significant difference related to spontaneously reported coping methods and Hopelessness. Therefore the null hypotheses was retained.

Several factors may account for this result. (a) There may in fact be no relationship of spontaneously reported coping behavior and hopelessness. (b) The apparent lack of significance may reflect the lack of variation in hopelessness scores. Recall that the

level of hopelessness in this sample was primarily minimal to mild. This narrow range of scores may not contain differences that would otherwise be evident when comparing individuals who are very hopeless and individuals who are very hopeful. (c) This may be a false retention of the null hypothesis due to an unrealistic separation of ways of coping. For example social support may include the person's community of faith, going to church, and praying with friends which would also be a form of spiritual coping. Other such combinations of coping are possible where one coping behavior is reported without providing evidence of the full range of behaviors associated within a given label.

As a point of interest, the spontaneously reported coping behaviors were consistent with the findings of Koenig, George, and Siegler (1988), who reported that spiritual coping, keeping busy, family, etc., were frequently reported coping behaviors of persons age 55-80.

The findings shown in Table 9 which suggest a curvilinear relationship between resurrection belief and hope parallels Aday (1984-1985), who found death anxiety was lower among both people who adhere closely

to traditional religious beliefs and those who reject such beliefs, and is higher among people who are undecided.

Due to lack of significant findings it would be inappropriate to make counseling recommendations concerning the reduction of hopelessness. However, it is reasonable to conclude that people actually cope with bereavement in a multitude of ways. In particular this sample frequently reported: keeping busy, talking with friends, spiritual coping, and family involvement (see Table 10). Such findings suggest that a holistic approach, such as the one used by hospice, remains in tune with the needs of the bereaved. By providing a multidisciplinary team to assist individuals with their physical, social, psychological and spiritual concerns, hospice programs effectively address the fundamental needs of many. A holistic approach to coping may also be quite beneficial when implemented by other bereavement counselors.

Most would agree that different perceptions of similar stressors generally result in differences in coping behavior. For example, a threat appraised as imminent would result in more immediate action. Most would also agree that different types of stressors

require different ways of coping. Therefore it benefits an individual to have multiple/holistic coping options. Generally, when a coping option proves effective, an individual will use that option again under similar circumstances. Individuals who become competent in the selection and use of effective coping skills are likely to be more hopeful than those who do not. When a coping option has served its purpose the individual may choose to address other concerns, rest, or do something else. However, when a coping option has not served its purpose the individual generally considers other options. Sadly, if an option does not provide the desired result, some individuals compulsively persist with heightened attempts to force a particular option to resolve the stressor, comparable to using key "A" to unlock door "B". Individuals who are afraid to explore untried options are likely to fixate on a narrow range of coping behaviors and have higher levels of hopelessness than individuals who utilize a variety of coping tools relevant to particular goals.

Recommendations For Future Research

This section briefly describes areas relevant to the current study, where additional research is needed. The order of presentation is not significant. Additional research is needed to gain a more complete understanding of the differences among bereaved individuals who feel hopeful and those who feel hopeless. There remains a need to identify coping behaviors that impair effective bereavement recovery or that contribute to feelings of hopelessness. Such research will require methods capable of attaining a wide range of hope-hopelessness responses. The self-selection bias on hopelessness may be greatly reduced by personal interviews.

Bereavement research would be enhanced by the development of an assessment inventory which is more sensitive to levels of hope and designed for older adults. Perhaps by combining elements of the Beck Hopelessness Scale, Herth Hope Scale, and Nowotny Hope Scale, with the Grief Resolution Index, a more sensitive and descriptive tool could be developed (Beck, 1974; Herth, 1986; Nowotny, 1989; Remondet & Hanson, 1987). Items could be designed based on

Worden's (1982) four tasks of mourning and Lazare's (1979) clues to unresolved grief. Thus the instrument would describe coping behaviors, level of hope, and progress toward grief resolution. The development of a short yet sensitive and reliable assessment inventory is no small task; however its potential usefulness would be great.

Longitudinal studies are needed to evaluate differences in the coping process among hopeful and hopeless bereaved spouses. Studies are needed to determine if coping patterns are consistent with current models of grief resolution. For example, longitudinal research to explore whether individuals who cope with bereavement in ways consistent with Worden's (1982) four tasks of mourning report higher levels of hope than individuals whose coping is more consistent with Lazare's 12 clues of complicated grief (1979).

Process issues of coping need to be explored. The current research was based on a view that there was loss followed by coping leading to some outcome of hope (Model 1). This rather simple model was convenient for initial research but does not reflect the more true to life interactive relationship of loss + other losses +

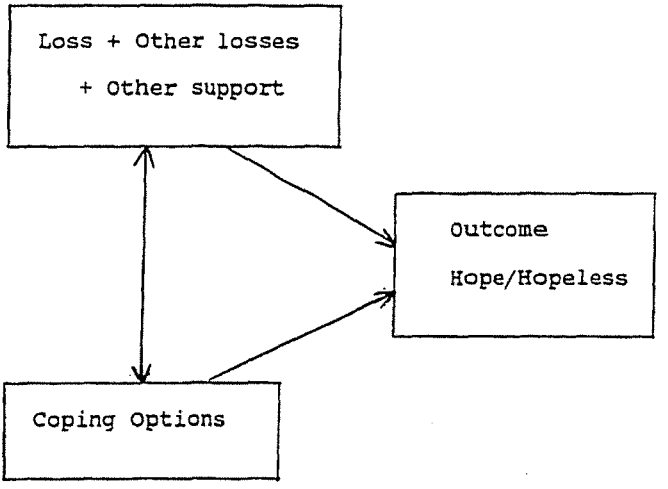
other support + coping + hope and the subsequent interactions (Model 2). See Figure 1.

Figure 1. Two models of the coping process.

Model 1:

Loss -> Coping Options -> Outcome of Hope/hopeless

Model 2:



Although we experience losses at all ages, loss in old age may differ in significant ways form earlier

loss. First, older people must adjust to concurrent losses in many different areas of their lives. Second, losses seem to be cumulative over the life span and the elderly tend to relive previous losses. Understanding the cumulative nature of grief is important for understanding loss among older people. The latest loss may be the proverbial last straw. Third, older people may find it more difficult to replace losses than younger people, in many cases there is a diminished support system (Waters & Goodman, 1990, pp. 135-136).

Research is needed to reveal how different perceptions of stressors change over time and how choices in coping are influenced by perceptions when feeling hopeful and hopeless. Such research would evaluate changes in coping behaviors as the participant moved from a state of feeling hopeless to becoming hopeful. Such research would address the participant's assessment concerning how s/he progressed from feeling hopeless to feeling hopeful (or the converse), including changes in appraisal of the expected effectiveness of coping behaviors. Perhaps an instrument similar to The Helpfulness of Prayer Scale (Saudia et al., 1991) could be developed to rate the effectiveness of a variety of coping options (see

Appendix K for the approximate form of the Helpfulness of Prayer Scale).

Further research is needed to develop an inventory to help caregivers understand the bereaved individual's afterlife beliefs and his or her concept of God. The topic of after-life beliefs is a much broader topic than belief or non-belief in the resurrection, even among those who identify themselves as traditional Christians and even more so when comparing different religions. Hospice and other care providers deal with many different religions and many different belief systems including: Catholics, Protestants, Seventh-Day Adventist, Jews, Later-Day Saints, Buddhists, Hindus, Muslims, Native Americans, New Age proponents, Humanists, Atheists, and many other belief groups. An inventory concerning after-life beliefs, and concept of God, designed to represent a variety of options reflecting the positions endorsed by major religions and philosophical perspectives could provide valuable understanding concerning the beliefs and values of the individual.

As the cultures of the world are more interrelated, their beliefs begin to reflect each others' perspectives. Many people endorse a variety of

beliefs that in the traditional sense of particular belief systems were exclusive of each other. An inventory to help the care provider understand the individual's afterlife beliefs and concept of God would be useful because an understanding of the client's beliefs and values is important in the formation of a therapeutic alliance, important when deciding therapy goals, and important during the development of treatment plans. Such an inventory should reflect the degree of certainty an individual has concerning each particular belief. Concept of God inventories already in use may provide a starting point for such an instrument (Spilka, Armatas, & Nussbaum, 1964; Gorsuch, 1968; Justice & Lambert 1986; Fisher, 1989; Gaultiere, 1989).

The role that confidence of belief or certainty of faith may have in promoting or maintaining hopefulness was demonstrated by Herth (1989). A significant difference ($p = .05$) was found between the participants' religious convictions and their level of hope and coping response. Participants who indicated a strong religious faith had significantly higher mean scores on the Herth Hope Scale and the Jalowiec Coping Scale than the mean scores of the other four groups

(weak, unsure, lost, or without faith). The question remains whether similar results will be found in other samples, and whether all strong religious beliefs are equally related to hope or whether differences in after-life belief contribute to differences in hopefulness.

There is a need for replication of the current study which includes participants from various cultural subpopulations and differing after life beliefs such as reincarnation, annihilation, fusion with the universe, divine evolution, and others to discover whether current research findings and counseling implications generalize to other groups.

Summary

Participants of this study were bereaved spouses of hospice patients. There were 75 females (mean age 67) and 21 males (mean age 60). Belief in the resurrection was endorsed by 86% of the participants (67% reported strong belief). A modified version of the Beck Hopelessness Scale suggested the level of hopelessness in this sample was primarily minimal to mild.

Two of the eight factors of the Ways of Coping Questionnaire-Revised showed significant negative correlations with Hopelessness: Positive re-appraisal and Planful Problem Solving. Two primary interpretations of this finding were presented: (a) participants who focus on personal growth or planful problem solving experience less hopelessness than participants using other means of coping, and (b) those participants who feel less hopeless are better equipped to reappraise stressors in terms of personal growth or employ planful problem solving than participants who coped by other means. Counseling implications include implementation of interventions which honor and encourage the client's ability to analyze and solve problems. Counseling interventions should also empower the bereaved to reappraise stressors in terms of personal growth, as a way to develop hopefulness, and should utilize hope where it exists to help clients reappraise stressors. This circular intervention is a bi-product of a correlational study which did not experimentally establish temporal precedence and, like all correlations, lacks the ability to prove causality.

Spiritual Coping had the third greatest negative correlation with Hopelessness, yet those findings were not significant ($p < .05$). Neither were the findings concerning the remaining factors: Self-Controlling, Confrontive Coping, Accepting Responsibility, Distancing, Seeking Social Support, or Escape-Avoidance. Such findings may be due to the genuine absence of any significant relationship, or due to a lack of participation among individuals with high levels of hopelessness.

No significant relationship was found between Hopelessness and Belief in the Resurrection. Limited hopelessness among participants and the small number of participants who strongly disagreed with belief in the resurrection made it difficult to draw meaningful conclusions concerning the possible relationship of resurrection beliefs and hopefulness.

A discriminant analysis revealed that bereaved spouses who reported strong belief in the resurrection more frequently utilized Seeking Social Support, Accepting Responsibility, and Spiritual Coping and less frequently used Escape-Avoidance than participants who held beliefs that were less certain about, or disagreed with, belief in the resurrection. Belief in the

Resurrection accounted for 22.5% of the variance in coping. About 71% of the participants were correctly classified as either believing strongly in the resurrection or not believing strongly in the resurrection. The canonical correlation coefficient was .4747.

Such finding demonstrated that resurrection beliefs and choice of coping behaviors are related, thus suggesting that there is value in understanding a bereaved client's after-life beliefs when developing treatment plans. Since resurrection beliefs are related to coping preferences it follows that understanding the bereaved client's after-life beliefs will contribute to the discovery of coping options that have higher compliance potential, since such coping options would be designed to be congruent with the individual's beliefs and subsequent coping preferences.

No significant differences in Hopelessness were observed between those who spontaneously reported Spiritual Coping and those who reported other ways of coping. Sample limitations (lack of hopelessness and lack of disbelief in the resurrection) may have confounded these results. There were also problems regarding which methods of coping are spiritual.

Nevertheless it was apparent that people cope with bereavement in a multitude of ways, and that keeping busy, talking with friends, Spiritual Coping, and family interactions reported by this sample are similar to the findings of other studies on coping. Such findings suggest that a holistic approach to counseling has the best probability of meeting the need of the bereaved.

This study demonstrated that certain coping behaviors are predictive of resurrection beliefs. Although belief in resurrection did not appear to be significantly related to more hopeful ways of coping, it was clear that spiritual ways of coping remain an important option among older adults who are coping with bereavement.

Recommendations for future research included additional exploration of differences among bereaved individuals who feel hopeful and those who feel hopeless. Longitudinal changes during the coping process needed to be explored. Research is needed to develope and improve instruments for measuring hope among bereaved older adults, including the development of instruments which address various after-life beliefs and measure aspects of grief resolution. Replication

of the current study needs to be done involving participants who are more hopeless and individuals who hold differing after-life beliefs.

It is hoped that this research will contribute to on-going efforts to develop effective counseling interventions (and assessment tools) to benefit people who are coping with bereavement. It is also hoped that this research will encourage others to explore how coping behaviors and spiritual beliefs are related to hope in a variety of populations.

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Appendix A

Introductory Letter To Hospice Directors

Mike Atkinson
G.F.C. - Research on Coping
420 N. Meridian Street, Box 5904
Newberg, Oregon 97132

Hospice Director
xxxxxxxxxxxxxxx
xxxxxxxxxxxxxxx

Dear

My name is Mike Atkinson and I am a student pursuing a doctorate in clinical psychology at George Fox College in Newberg, Oregon. For my dissertation I am investigating whether particular coping behaviors and/or select beliefs are predictors of level of hope among bereaved spouses of hospice patients.

One of the most difficult aspects of any research is finding participants. I am seeking an opportunity to invite bereaved spouses to participate in this study by completing a mailed survey. All participation will be voluntary and anonymous.

Participants may gain insight into his or her coping methods and perhaps discover additional ways of coping. Participants may also gain personal satisfaction from providing information which contributes to a better understanding of bereavement and thereby contributes to more effective bereavement counseling.

To provide a further description of what is involved, I have enclosed a copy of the introductory letter and a copy of the participant's instructions. Hopefully these items will capture your interest and answer some of your questions.

Helping people cope with loss has been a major focus of mine for several years. Practicum experience included providing bereavement counseling with Mt. Hood Hospice, and co-facilitating the Survivors of Suicide Group at Hospice House (now Hopewell House). I am certified as a Hospice Volunteer by Portland Adventist Hospice. Prior to moving to Oregon, I was briefly involved with public relations for Hospice of the Valley in Phoenix, Arizona.

I will call you next week to answer any questions you may have about this research. Perhaps we can arrange a time to meet in person. I would very much like to meet with you to show you the survey and discuss any additional details of this research that interest you.

Sincerely,

Mike Atkinson, MA
H (503) xxx-xxxx
W (503) xxx-xxxx

Appendix B

Letter From Hospice Introducing Research

Dear Hospice Family Member:

Enclosed is a letter from Mike Atkinson, a certified hospice volunteer who formally provided bereavement counseling for individuals served by Mt. Hood Hospice and Hospice House (now Hopewell House). Presently he is working on his doctoral dissertation. His work has the potential of contributing to the field of bereavement support counseling.

We invite you to take part in this research concerning coping with the death of a spouse. A relatively small number of people are being contacted to participate so your response is greatly valued.

We realize that this touches tender areas of your life, and we want you to know that you are not obligated to complete this questionnaire. Participation is voluntary and all responses will be kept strictly confidential. Mike has asked me to contact you on his behalf because he respects the confidentially of our records.

Thank you for your willingness to help with this research and in turn help others as you walk through these memory-filled days.

Sincerely,

Bereavement Coordinator

Appendix C

Invitation to Participate in Research

Dear Sir or Madam:

The death of a spouse has long been considered one of the most stressful events in the human experience, yet there is little research concerning what people actually do to cope with such a loss. Therefore, we are surveying recently bereaved people to gain a better understanding of how people cope with the death of a spouse.

The materials you have received are your invitation to participate in our research by simply completing the enclosed survey. Your anonymous participation provides important information that would otherwise be unavailable. Such information may contribute to a better understanding of how people cope with grief and may provide insights for bereavement counseling. Completing this survey may enhance your understanding of your own grief or help you consider additional ways of coping. Your participation in this study is greatly desired but the decision to participate is completely up to you.

Participation involves responding to multiple choice questions regarding your coping behaviors, beliefs, thoughts, and feelings. There are a few questions that are answered with a few words or a sentence. It will take approximately 30 to 50 minutes to complete this survey.

If you would like a summary of our research findings, please write to the address below. The information will be sent to you following the completion of the study. Individual information is confidential and such results will not be available.

Attention: Coping With Bereavement
Box 5904
George Fox College Department Of Clinical Psychology
414 North Meridian Street
Newberg, Oregon 97132-2697

To participate, read the instructions on the next page and complete the survey at your first opportunity. Please keep in mind the finding that most people, though well intended, will forget to respond to questionnaires if they do not do so within 48 hours. A prompt response is needed so the results can be evaluated. When finished, mail your completed survey using the addressed postage-paid envelope that has been provided for your convenience.

Thank you very much for your invaluable assistance and time. The participation of people like yourself is vital to the successful completion of this study.

Sincerely,
Mike Atkinson, M.A.
Research Director

P.S. If you are not able to participate please return the unused materials in the envelope provided.

Appendix D

General Instructions and Overview of the Survey

Dear Research Participant,

Thank you for your willingness to participate in this study of coping with bereavement. Your contribution is greatly appreciated.

GENERAL INSTRUCTIONS Do not write your name on any of these materials. Participant's confidentiality is insured in this way.

Your voluntary consent to participate is implied when you complete the enclosed questionnaires. You have the option to discontinue responding at your discretion. No explanation is required, however your suggestions on how to improve the study are appreciated.

Please complete the questionnaire in a quiet, distraction-free environment. If you are unsure about an item, simply do your best to respond without seeking an interpretation from another person.

SOMETHING DIFFERENT Traditionally, questions requiring a written response are introduced near the end of a survey. We have elected to depart from that tradition so your written responses can be more spontaneous and free from the possible influence of other questions contained in this survey. Only 8 questions involve your written response. Generally a sentence or a few descriptive words will suffice. The majority of questions in the survey simply require you to circle a number corresponding to the choice that best reflects your thoughts, feelings, behaviors or beliefs.

OVERVIEW This survey is comprised of three sections. Please respond to every question in the order of appearance. Be careful not to skip any questions.

The first section of the survey has 20 questions about stressors, coping, and beliefs. Instructions are provided as you proceed.

The second section: The Ways Of Coping Questionnaire, is comprised of 70 statements originally designed to apply to a wide range of stressful experiences. We are using this instrument to learn how people cope with bereavement. Detailed instructions are provided prior to this section's first item.

The final section has 20 statements. You are asked to indicate the extent to which a statement is or is not descriptive of your thoughts and feelings. Detailed instructions are provided prior to this section's first item.

After completing the survey you are invited to write your thoughts and feelings about this survey, and the research topic, in the space following the last question (Optional).

Appendix E

Demographic Questionnaire-Original

SECTION ONE

Q-1 Your present age: ___ YEARS

Q-2 Your Sex. (Please circle number)

1 MALE

2 FEMALE

Q-3 How did your spouse die? (Please circle number)

1 HEART ATTACK, STROKE OR OTHER SUDDEN PHYSICAL CONDITION.

2 CANCER, AIDS, CHRONIC DISEASE OR OTHER LINGERING ILLNESS.

3 ACCIDENT

4 SUICIDE

5 MURDERED

6 OTHER: _____

Q-4 When did your spouse die? Month: _____ Year: _____

Q-5 Since the death of your spouse, what has been the most difficult thing for you to cope with?

_____

Q-6 Complete the following statement. While experiencing the above stressor (see Q-5), I often feel...

_____

Q-7 What is your primary way of coping with this (Q-5) stressor?

_____

Q-8 Rate the effectiveness of the above (Q-7) coping method.

1 VERY INEFFECTIVE

2 SOMEWHAT INEFFECTIVE

3 SOMEWHAT EFFECTIVE

4 VERY EFFECTIVE

Q-9 What, if anything, contributes to a sense of hope in your life?

_____

For Q-10 through Q-17 please read each statement and use the following code to indicate the extent of your agreement or disagreement with each statement. Circle the number to indicate your response.

1 = STRONGLY AGREE
2 = MODERATELY AGREE
3 = SLIGHTLY AGREE
4 = SLIGHTLY DISAGREE
5 = MODERATELY DISAGREE
6 = STRONGLY DISAGREE

Q-10 1 2 3 4 5 6 I believe in reincarnation.

Q-11 1 2 3 4 5 6 I believe in a literal and eternal hell.

Q-12 1 2 3 4 5 6 I believe that after death there is no "after life" of any kind.

Q-13 1 2 3 4 5 6 I believe that all people will live with God forever.

Q-14 1 2 3 4 5 6 I believe that people who have been spiritually reborn through faith in Jesus Christ will be resurrected from the dead to live eternally with God.

Q-15 1 2 3 4 5 6 I believe that the good and bad things a person does during his or her lifetime determines that person's eternal destiny.

Q-16 1 2 3 4 5 6 I believe in purgatory.

Q-17 1 2 3 4 5 6 I believe in baptism for the dead and that it is man's destiny to evolve to Godhood.

Q-18 Do you profess to be a Christian? (Circle the number corresponding to the response which best describes you.)

1 NO

2 YES, I RESPECT AND ATTEMPT TO FOLLOW THE MORAL AND ETHICAL TEACHINGS OF CHRIST.

3 YES, I HAVE RECEIVED JESUS CHRIST INTO MY LIFE AS PERSONAL SAVIOR AND LORD.

4 YES, I HAVE RECEIVED JESUS CHRIST INTO MY LIFE AS PERSONAL SAVIOR AND LORD AND I SEEK TO FOLLOW THE MORAL AND ETHICAL TEACHINGS OF CHRIST.

Q-19 Is there anything you would like to say to further express your beliefs about what happens after death?

Q-20 In what ways, if any, has the death of your spouse affected your spiritual beliefs, spiritual behaviors and your thoughts and feelings about God?

Appendix F

Demographic Questionnaire-Revised

SECTION ONE

Today's Date: _____

Q-1 Your present age: ___ YEARS

Q-2 Your Sex. (Please circle number)

1 MALE

2 FEMALE

Q-3 How did your spouse die? (Please circle number)

1 HEART ATTACK, STROKE OR OTHER SUDDEN PHYSICAL CONDITION.

2 CANCER, AIDS, CHRONIC DISEASE OR OTHER LINGERING ILLNESS.

3 ACCIDENT

4 SUICIDE

5 MURDERED

6 OTHER: _____

Q-4 When did your spouse die? Month: _____ Year: ____

Q-5 Since the death of your spouse, what has been the most difficult thing for you to cope with?

_____

Q-6 Complete the following statement. While experiencing the above stressor (see Q-5), I often feel...

_____

Q-7 What is your primary way of coping with this (Q-5) stressor?

_____

Q-8 Please rate the effectiveness of the coping method described in response to Q-7.

1 VERY INEFFECTIVE

2 SOMEWHAT INEFFECTIVE

3 SOMEWHAT EFFECTIVE

4 VERY EFFECTIVE

Q-9 What, if anything, contributes to a sense of hope in your life?

_____

A basic question of humanity over many ages has been, "What happens after we die?". There is great diversity of belief concerning the "after life". We acknowledge your right to believe as you choose. It was impossible to include every option so question Q-12 was included to provide an opportunity for you to briefly describe your beliefs in your own words.

Please read Q-10 and Q-11 carefully and indicate the extent of your agreement or disagreement with each statement by circling the number corresponding to the following code:

1 = STRONGLY AGREE
: 2 = MODERATELY AGREE
: : 3 = SLIGHTLY AGREE
: : : 4 = SLIGHTLY DISAGREE
: : : : 5 = MODERATELY DISAGREE
: : : : : 6 = STRONGLY DISAGREE
: : : : : :
: : : : : :

Q-10 1 2 3 4 5 6 I believe that people who have been spiritually reborn through faith in Jesus Christ will be resurrected from the dead to live eternally with God.

Q-11 1 2 3 4 5 6 I believe that after death there is no "after life" of any kind.

Q-12 Is there anything you would like to say to further express your beliefs about what happens after death?

_____

_____

_____

Appendix G

Instructions for Mailing Surveys and Keeping Records

Dear Hospice Staff,

Please keep a record of the names and addresses of each person that will receive a research packet (introduction letter, instructions & survey) for this study. Use the following address form for that purpose.

It is important that each participant's name and address corresponds to his or her code number. Each person's Code number can be found on the back of the envelope containing his or her research materials. The code numbers are only used for keeping track of which people return the survey and which people will be sent a gentle and thankful reminder to return the survey.

If anyone should ask about the code number please let the person know that no one will match any person's name with his or her answers to the survey questions. The information will be kept completely confidential and anonymous. The list of names and addresses will be destroyed after all research materials have been returned (or after six weeks which ever comes first).

If you have any questions please call me at home.

Thank You Sincerely,

Mike Atkinson,
Research Director
Home: (503) xxx-xxxx

Appendix H

Participant's Address Form

PARTICIPANT'S ADDRESS FORM

CODE
NUMBER

A09 NAME: MIKE ATKINSON

ADDRESS: RESEARCH ON COPING,

G.F.C.

420 N Meridian Street, BOX 5904

CITY, STATE & ZIP: NEWBERG, OR 97132-2699

Y01 NAME: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

Y02 NAME: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

Y03 NAME: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

Y04 NAME: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

Y05 NAME: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

Appendix I

Letter Reminding Participants to Reply

George Fox College
Research On Coping With Bereavement
414 North Meridian Street, Box 5904
Newberg, Oregon 97132-2697

Dear Research Participant,

A few days ago you were invited to participate in research investigating how people cope with bereavement. A survey was provided as a way for you to express your thoughts, feelings, and behaviors concerning how your are coping with the death of your spouse.

If you have already completed the survey, and mailed it back to us, please accept our sincere thanks for your participation and for your prompt response.

Each completed questionnaire contributes to a better understanding of how people actually cope with bereavement and may provide valuable insights for bereavement counseling. Your participation is an important part of developing this understanding.

If you intend to complete the survey, but have not "gotten around to it yet", there is still time to participate and your responses are still very much desired. Please complete the survey at your first opportunity, today if possible, and mail it to us using the pre addressed and postage-paid envelope which was provided for your convenience.

If you decided not to complete the survey, please return the unused materials. Also remember that your suggestions concerning how this research could be improved are appreciated.

Best Wishes
Sincerely,

Mike Atkinson, MA
Research Director

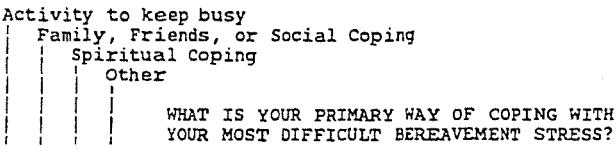
Appendix J

Form for Classification of Spontaneous Coping Responses

The death of a spouse is considered to be an extreme stressor. In a recent survey, 97 bereaved spouses reported how they cope with bereavement stress. The actual responses are presented below. Many individuals reported the same or similar ways of coping in a variety of combinations. Please read each response carefully and determine which of the following 4 categories describe each response:

A = Activity to keep busy
F = Family, Friends, or Social Coping
S = Spiritual Coping
O = Other

Use your best judgement to discern which if any category is most descriptive of the coping behavior. When the coping behavior is uniquely described by one category circle only one letter, either: "A", "F", "S", or "O". If the coping behavior(s) is (are) best described as "A+F", "A+S", "S+O" or any other combination, please circle EACH LETTER THAT IS APPLICABLE TO THAT COMBINATION of coping behaviors.



01. A F S O Taking care of my grandsons.

02. A F S O Keep working and praying.

03. A F S O Cry. Call people. Have coffee with a neighbor and talk about other things - usually gardening.

04. A F S O Keep busy with things that have to be done.

05. A F S O Leave the radio on when I leave the house.

06. A F S O I cry.

07. A F S O Keeping busy.

08. A F S O Work, reading, sometimes talking.

09. A F S O Talk to Jesus, and reading the Psalms and God's word.

Activity to keep busy
Family, Friends, or Social Coping
Spiritual Coping
Other

					WHAT IS YOUR PRIMARY WAY OF COPING WITH YOUR MOST DIFFICULT BEREAVEMENT STRESS?
10.	A	F	S	O	Keep busy.
11.	A	F	S	O	Haven't found it yet.
12.	A	F	S	O	Go for a walk - call someone.
13.	A	F	S	O	Patience
14.	A	F	S	O	Being with people.
15.	A	F	S	O	Taking a walk - going shopping - getting out among people.
16.	A	F	S	O	Keeping busy and volunteering.
17.	A	F	S	O	Try to keep busy.
18.	A	F	S	O	Getting massages. Ask relatives to leave.
19.	A	F	S	O	Keep working.
20.	A	F	S	O	Talking to people.
21.	A	F	S	O	Asking for help from God.
22.	A	F	S	O	Thinking of good memories.
23.	A	F	S	O	Keeping busy with friends. Getting out of the house.
24.	A	F	S	O	Seek additional information.
25.	A	F	S	O	I just think to myself, he is still with me.
26.	A	F	S	O	Keeping busy, being with relatives and friends.
27.	A	F	S	O	Gardening - music - meditation.
28.	A	F	S	O	Go visit friend or family.

	A	F	S	O	WHAT IS YOUR PRIMARY WAY OF COPING WITH YOUR MOST DIFFICULT BEREAVEMENT STRESS?
					A = Activity to keep busy F = Family, Friends, or Social Coping S = Spiritual Coping O = Other
29.	A	F	S	O	Reassure myself that I am doing all that is possible, and not worry about what is out of my control.
30.	A	F	S	O	Keep very busy.
31.	A	F	S	O	Discuss the matter with oldest daughter.
32.	A	F	S	O	Talking with someone in the family.
33.	A	F	S	O	Crying and then getting busy.
34.	A	F	S	O	Keep active, choir, swimming, being with friends.
35.	A	F	S	O	Talking with other parents and older adults.
36.	A	F	S	O	Cry - I do not cope with it at this time.
37.	A	F	S	O	Work
38.	A	F	S	O	I have God with me at all times.
39.	A	F	S	O	Walking - TV or radio for noise.
40.	x	x	x	x	(NO ANSWER)
41.	A	F	S	O	Crying - going to bed.
42.	A	F	S	O	Focusing on doing something for another person.
43.	A	F	S	O	Listening to the TV and reading.
44.	A	F	S	O	Spending time with friends or shopping.
45.	A	F	S	O	Do it!
46.	A	F	S	O	Keep occupied.
47.	A	F	S	O	Get out of the house.

	A = Activity to keep busy	F = Family, Friends, or Social Coping	S = Spiritual Coping	O = Other	WHAT IS YOUR PRIMARY WAY OF COPING WITH YOUR MOST DIFFICULT BEREAVEMENT STRESS?
48.	A	F	S	O	Try to stay busy, helping others.
49.	A	F	S	O	Telling myself that I am a good person and that I did what I could over the years.
50.	A	F	S	O	Go to work.
51.	A	F	S	O	Knowing that we can't change things and to go on.
52.	A	F	S	O	Activity and Bible study.
53.	A	F	S	O	Working all the time.
54.	A	F	S	O	Working in my beautiful yard.
55.	A	F	S	O	Immersion with kids.
56.	A	F	S	O	Friends and family.
57.	A	F	S	O	Visiting her grave and talking with her.
58.	A	F	S	O	Just Do it.
59.	A	F	S	O	Exercise, volunteer work, reading the Bible and positive literature is comforting.
60.	A	F	S	O	Talk to my husband mentally and/or aloud to his photo.
61.	A	F	S	O	Thinking of present and future relationships.
62.	A	F	S	O	Accepted that he will not be back. Got busy. Church and pastor were greatly helpful.
63.	A	F	S	O	Being busy - planning activities with children and grandchildren.
64.	A	F	S	O	Concentrating on keeping active.

	A = Activity to keep busy	F = Family, Friends, or Social Coping	S = Spiritual Coping	O = Other	WHAT IS YOUR PRIMARY WAY OF COPING WITH YOUR MOST DIFFICULT BEREAVEMENT STRESS?
65.	A	F	S	O	Keep busy and association with people.
66.	A	F	S	O	Keep busy
67.	A	F	S	O	Working outside or house cleaning.
68.	A	F	S	O	Spend time with others if possible but I have started to feel better if I can have time to myself.
69.	A	F	S	O	Work
70.	A	F	S	O	Reading a novel to escape reality.
71.	A	F	S	O	I tell myself I must enjoy for 2 and not become down hearted - God has been good to us.
72.	A	F	S	O	Work
73.	A	F	S	O	Keeping busy
74.	A	F	S	O	Being with my children and friends.
75.	A	F	S	O	Take one day at a time. Ask God for strength.
76.	A	F	S	O	The Lord and good friends, family, and church family.
77.	A	F	S	O	Reading a good book or spending time building my model rail road.
78.	A	F	S	O	Keep busy.
79.	A	F	S	O	Talk out loud, sometimes to myself when I have to make big decisions.
80.	A	F	S	O	Do something - go pull weeds
81.	A	F	S	O	Counselor
82.	A	F	S	O	Keep busy. Not dwelling on it.

	Activity to keep busy	Family, Friends, or Social Coping	Spiritual Coping	Other	WHAT IS YOUR PRIMARY WAY OF COPING WITH YOUR MOST DIFFICULT BEREAVEMENT STRESS?
83.	A	F	S	O	Use resources to get questions answered.
84.	A	F	S	O	I talk out loud to him about the things I did.
85.	A	F	S	O	Get in my car and drive - anywhere!
86.	A	F	S	O	I remarried.
87.	A	F	S	O	I go away on trips to visit my family out of state.
88.	A	F	S	O	Believing in the Lord.
89.	A	F	S	O	Prayer and Bible promises.
90.	A	F	S	O	Drinking - Praying
91.	A	F	S	O	I try not to get down - enjoy games, talking with grandchildren. My daughter and sons are a great comfort.
92.	A	F	S	O	Keeping busy - visiting his relatives.
93.	x	x	x	x	{NO ANSWER}
94.	A	F	S	O	Just keeping busy, and especially carrying out the ideas as my husband would have done if he had lived.
95.	A	F	S	O	Try to find something to do or watch TV.
96.	A	F	S	O	Calling on my support system...talking to my true friends. Journaling is also a main "sanity saver".
97.	A	F	S	O	Being with my children - Trying to do volunteer work.

Appendix K

Helpfulness of Prayer Scale

Code # _____

Date: _____

Instructions:

Several methods have helped people relax while getting ready for cardiac surgery. Prayer as communication with a Higher Being is one method found to help people cope with the stress of surgery. Please indicate whether this method is helpful to you. Rate how helpful on the scale provided.

1. Have you used prayer to help you prepare for cardiac surgery?

_____ YES

_____ NO

If yes, how helpful was it?

0 1 2 3 4 5 6 7 8 9 10 11 12

Not at all helpful — Extremely helpful

Appendix L

Raw Data Tables

Explanation of Raw Data Table

First Set Column

1-2: Participant Identification Number

3-4: Age of Participant

5: Gender of Participant

1 = Male

2 = Female

6: Type of Death

1 = Heart Attack or Sudden Death

2 = Chronic, Lingering Illness

3 = Accident

4 = Suicide

5 = Murder

6 = Other

7-8: Months of Bereavement

9: Participant's Rating of Effectiveness of Primary Coping Method

1 = Very Ineffective

2 = Somewhat Ineffective

3 = Somewhat Effective

4 = Very Effective

10: Resurrection Belief based on, "I believe that people who have been spiritually reborn through faith in jesus Christ will be resurrected from the dead to live eternally with God".

1 = Strongly Agree

2 = Moderately Agree

3 = Slightly Agree

4 = Slightly Disagree

5 = Moderately Disagree

6 = Strongly Disagree

11: Belief in Afterlife based on, "I believe that after death there is no afterlife of any kind".

1 = Strongly Agree

2 = Moderately Agree

3 = Slightly Agree

4 = Slightly Disagree

5 = Moderately Disagree

6 = Strongly Disagree

Second & Third Set Column

1-70	Ways Of Coping Questionnaire- Revised
(1-70 was printed as = 1-66 & 1-4)	
6,7,17,28,34,46	Confrontive Coping
12,13,15,21,41,46	Distancing
10,14,35,43,54,62,63	Self-Controlling
8,18,22,31,42,45	Seeking Social Support
9,25,29,51	Accepting Responsibility
11,16,33,40,47,50,58,59	Escape-Avoidance
1,26,39,48,49,52	Planful Problem Solving
20,23,30,38,56	Positive Reappraisal
36,60,67,68,69,70	Spiritual Coping

Fourth Set Column

1-20 20 Items of the Beck Hopelessness Scale

1 = Strongly Agree

2 = Moderately Agree

3 = Slightly Agree

4 = Slightly Disagree

5 = Moderately Disagree

6 = Strongly Disagree

Fifth Set Column (see pp. 232-234).

1-2: Participant Identification Number

3-7: Rating given to Spontaneously Reported Means of Coping and...

8: Most Prevalent Rated Means of Coping

1 = Activity to Keep Busy

2 = Family Friends Social

3 = Spiritual Coping

4 = Spiritual Combined

5 = Other

6 = Mixed Non-Spiritual

7 = No Answer

9-13: Rating given to Spontaneously Reported Source of Hope

1 = Positive Reappraisal

2 = Family Friends Social

3 = Spiritual Coping

4 = Spiritual Combined

5 = Other

6 = Mixed Non-Spiritual

7 = No Answer

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Appendix M

Vita

Vita

MICHAEL ATKINSON, M.A.
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GRESHAM, OREGON 97030
(503) 492-4835

CAREER OBJECTIVE: Licensed Clinical Psychologist

EDUCATION

1995 Psy.D. (Anticipated) Clinical Psychology
George Fox College
Newberg, Oregon

1990 M.A., Clinical Psychology
Western Conservative Baptist Seminary
Portland, Oregon

1985 B.S., Psychology
Arizona State University
Tempe, Arizona

PRACTICUM EXPERIENCE

1990 Lutheran Family Services
Portland, Oregon

1989 Mt. Hood Hospice
Sandy, Oregon

1989 Hospice House (Now: Hopewell House)
Portland, Oregon

1988 Portland Adventist Convalescent Center
Portland, Oregon

Practicum experience included individual counseling for depression, self-esteem, bereavement, suicide grief recovery group, marital counseling, personality assessment, and evaluation and treatment of older adults.

PSYCHOLOGY INTERNSHIP

1993-94 Sundstrom and Associates, PC
Clackamas, Oregon

Individual counseling related to mood disorders, marital counseling, loss issues, geropsychological assessment.

EMPLOYMENT

1995-Present — Ceres Behavioral Healthcare
Portland, Oregon
Lead Triage Therapist
Intake evaluations, crisis counseling, and utilization of community mental health centers, liaison with primary care physicians to facilitate psychiatric hospitalizations.

1991-93 — The Ryles Center For Evaluation & Treatment
Portland, Oregon
Qualified Mental Health Professional
Individual counseling, assessment and treatment planning of chronically mentally ill adults, lead community groups, substitute team leader.

1990-92 — George Fox College
Graduate School of Clinical Psychology
Newberg, Oregon
Graduate Fellow, Practicum Supervisor
Supervised small groups of practicum students and provided pre-practicum training.

1988 — Rosemont
Portland, Oregon
Relief Residential Counselor
Individual counseling for adolescent girls who had behavioral and emotional issues.

1986-87 — Arizona Baptist Children's Services
Glendale, Arizona
Residential Counselor
Individual counseling for adolescent boys who had behavioral and emotional issues, taught problem solving skills, planned activities.

1984-85 — Arizona State University
Tempe, Arizona
Research Assistant: Older Adults Research Program. Helped with the design of research materials, conducted health screenings, interviewed confidants.

1975-Present — Professional Photographer
Photography resume available upon request

RELATED EXPERIENCE

1994-95 Alzheimer's Association - Columbia Chapter
Volunteer Support Group Leader

1994-95 St. Vincent DePaul
Job Coach for Developmentally Disabled Adults

1994 Introduction to American Sign Language

1990 Portland Adventist Medical Center
Certified Hospice Volunteer

1990 Veterans Administration Hospital
Student Chaplain

1989 New Hope Community Church
Grief Recovery Group

1983-84 Arizona State University
Research Assistant:
Cultural Factors of Attraction
Effects of Heat on Aggressive Behavior

ASSESSMENT SKILLS

Beck Depression Inventory, Beck Hopelessness Scale, Bender-Gestalt, Folstein Mini Mental State, Fuld Object-Memory Evaluation, MMPI, Geriatric Depression Scale, Mental Status Exam, Sentence Completions, Stanford-Binet 4th Ed., WAIS-R, WISC III, and Thematic Apperception Test.

PRESENTATIONS GIVEN

Perspectives in Brief Therapy, Introduction to Hospice, Dementia and Alzheimer's Disease, Psychological Impact of Physical Disability, Psychological Impact of Infertility, Understanding Guilt and Shame, Therapy with Polarized Couples.

DISSERTATION

The Relationship of Coping Behaviors, Resurrection Beliefs and Hopelessness Scores Among Bereaved Spouses of Hospice Patients.