UNIVERSITY OF SOUTHAMPTON

FACULTY OF MEDICINE, HEALTH, & LIFE SCIENCES

School of Psychology

The Role of Religious and Spiritual Belief and Practice in Coping and Adjusting to Spousal Bereavement in Later Life

By

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ABSTRACT

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THE ROLE OF RELIGIOUS AND SPIRITUAL BELIEF AND PRACTICE IN COPING AND ADJUSTING TO SPOUSAL BEREAVEMENT IN LATER LIFE

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The death of a spouse is a distressing life event that is most common in later life. Recently, a small body of research has suggested that religion and spirituality can have a beneficial influence on bereavement outcome. The aim of the present thesis was to investigate how Christian religious/spiritual belief and practice can facilitate coping and adjustment to spousal bereavement in later life.

The present thesis reports four studies, two qualitative and two quantitative. Study 1 was a longitudinal follow-up of survivors from a previous study of spousal bereavement, and investigated experiences of longer term coping and adjustment. Results identified that participants used both religious and secular resources in adjustment and that those with a strong religious belief reported adjustment marked by the least difficulties. Study 2 focused on older adults with a strong Christian belief and aimed to identify the religious content and practice most important in coping with spousal bereavement. Interpretative phenomenological analysis revealed four main themes: benevolent religious cognition, Biblical assurances, religious ritual, and spiritual capital, that in different ways were related to meaning reconstruction. As religious ritual seemed important yet is under researched, Study 3 aimed to develop the first scale of its kind to measure religious ritual. A 35-item scale was developed, named the Importance of Religious Ritual Scale, and psychometric properties were provided including factor structure, construct validity, internal consistency reliability, and temporal reliability. Study 4 included the religious ritual scale in a cross-sectional study comparing salient religious and secular variables in predicting grief, depression, and anxiety in recently bereaved older adults. Results revealed that high importance of religious ritual was a predictor of lower grief and depression; and daily spiritual experience was a predictor of lower anxiety.

It is proposed that benevolent religious beliefs and religious scripture are used in meaning-making processes, while religious ritual and religious/spiritual emotions are primarily used in managing and regulating grief-related affect. Findings are discussed within existing bereavement theory.

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DECLARATION OF AUTHORSHIP

I, John Henry Spreadbury, declare that the thesis entitled 'The Role of Religious and Spiritual Belief and Practice in Coping and Adjusting to Spousal Bereavement in Later Life', and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission.

Signed:……

Dated:…….

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ABBREVIATIONS

BAQ	Bereavement Activities Questionnaire
BEI	Bereavement Experiences Index
BIDR	Balanced Inventory of Desirable Responding
BMMRS	Brief Multidimensional Measure of Religiousness/Spirituality
CPS	Culturally Postulated Superhuman (agents)
DPM	Dual Process Model
ECR	Experiences in Close Relationship scale
ECR-S	Experiences in Close Relationship scale short-form
GDS	Geriatric Depression Scale
HAD-A	Hospital Anxiety and Depression Scale – Anxiety subsection
ICG	Inventory of Complicated Grief
IM	Impression Management
IPA	Interpretative Phenomenological Analysis
MOS	Medical Outcomes Study
NIA	National Institute of Ageing
PCA	Principal Component Analysis
PMI	Personal Meaning Index
QOL	Quality Of Life
SDE	Self-Deceptive Enhancement
SF-36	Short-Form 36-item Health Survey
SWLS	Satisfaction With Life Scale
WHOQOL-BREF	World Health Organisation Quality of Life abbreviated version of the WHOQOL-100
WHOQOL-100	World Health Organisation Quality of Life assessment scale

PREFACE

The following preface provides a brief introduction and overview of the thesis to follow. The present thesis explores the role played by religious and spiritual belief and practice in older adults coping and adjusting to spousal bereavement. In approaching the present thesis perhaps one of the first questions one may ask is why study from the perspective of psychology, religion and the closely related concept of spirituality? In addition, a second question may be, in the context of coping with bereavement in later life why study religion instead of other potential resources?

In addressing the first question, religion is of interest for several reasons. For example, religion is a distinctive and unique feature of human nature and human functioning, and despite in some cases strong scientific evidence to refute the claims of certain religions, religion has maintained a persisting and universal presence. Also, religion has shaped much of the world's civilisations with Christianity in particular influencing much Western human societal development that even today at some level still exerts an influence on people's lives. Furthermore, in some societies religion continues to have a strong and observable social, political, and economic influence while at the level of the individual religion is recognised as in some cases having a strong influence on decision making, emotion, and behaviour. Indeed, some of the most recent and dramatic world changing events such as the terrorist attacks of "9/11" have had religious antecedents, consequences, and connotations.

In addition, up to 85% of the world's population is considered to have some kind of religious belief (cited in Sedikides, 2010) while in Great Britain, a country considered secular, a national Census survey found that up to 77% of the population reported having a religion, with the majority of people reporting an identification with Christianity. However, despite these observations that testify to the prevalence and influence of religion at multiple levels of people's lives, within the academic discipline of psychology and the wider social and life sciences, religion has been a neglected topic of theory and research.

The most common explanations for why religion has been neglected have included that for much of the 20th Century religion was viewed negatively by theorists, for example as a defence mechanism, as wishful thinking, as irrational, or as pathological and was therefore considered of little value to research (Coleman, 2010; Sedikides, 2010). Also, perhaps related to this view was that during a time dominated by behaviourism and the cognitive revolution, the subject of religion was seen as being too intangible, ineffable, and subjective to be studied scientifically. Furthermore, the study of religion has not been considered a research priority in

leading psychology departments and by funding councils, while conducting research on religion was viewed as potentially harmful to an academic's career (Levin, 1994; Sedikides, 2010). Moreover, psychologists have been found to be less religious than the general public and may therefore feel that they lack sufficient knowledge or experience to approach the subject or may simply feel indifferent, unsympathetic, or opposed to religion (Hill et al. 2000). However, despite the former neglect the past 10 to 15 years has seen a gradual increase of interest in research on religion especially in relation to health, well-being, and ageing, and we are now witnessing more openness toward research on religion with religion beginning to be the subject of significant research attention in such areas as mainstream social psychology (see Sedikides, 2010).

Although Britain has seen a gradual decline in church attendance and religious affiliation since the end of World War Two there has not necessarily been an accompanying embracing of agnosticism, atheism, or humanism (although these perspectives have no doubt become more popular). Indeed, one interpretation on the state of religion in contemporary Britain is that there has been an increase in religious uncertainty. With the perceived gradual erosion of the different forms of social and moral authority of the different religions, but perhaps particularly Christianity, many British people may have become increasingly uncertain in what they believe and uncertain in how to express their belief. Indeed, it has been widely observed that since the 1960s many younger people have been more inclined to develop their own personal spiritualities drawing on religious concepts from new age spiritualities, Paganism, Christianity, Buddhism, and Hinduism (Coleman, 2010). Therefore, while many British people still have the potential to turn to or be influenced at some level by religion in its various forms, it is of interest to research religion and understand how religion functions and is used.

With regard to answering the second question, there are several reasons for studying religion in the context of bereavement in later life. Perhaps one of the most interesting reasons is that in comparison with other factors salient to coping with bereavement, religion may be a unique resource that may have distinct potential benefits or therapeutic properties. Whereas other factors or resources such as social support, the circumstances of the bereavement, or even counselling can be involved in coming to terms with the loss, in gradual readjustment, and in preventing social loneliness, these factors may be less helpful in addressing the existential issues, questions, or concerns that can be evoked by a significant bereavement. In this respect religion can provide sources of meaning or ways of understanding bereavement, loss, and death that can be experienced as more personal, profound, or philosophical than reliance on rational details about the loss itself and can in different ways be experienced as helpful or beneficial.

Indeed, despite much anecdotal evidence to testify to the usefulness of religion in circumstances of bereavement, as will be highlighted in Chapter 2, in-depth research into how religion is helpful in bereavement has yet to be explored beyond the superficial.

In addition, for many British older adults, religion, or more specifically the Christianity that many older adults were brought up with, may still be important. As discussed by Coleman (2010) the majority of contemporary British older adults were socialised during a much more religious time whereby attendance at Sunday school was an important part of their upbringing. As such, Christianity is still a part of the identity of many British older adults even if religion is not now a central part of their life. This religious upbringing may have formed the basis for making an informed decision during their lives to reject the Christianity of their upbringing or may provide the link to return to religion in later life or in times of crisis such as bereavement. Therefore, for many British older adults, unlike other potential resources that can decline in later life or may be more difficult to acquire (e.g. social support from friends or family, financial resources, health), religion is a potentially accessible resource available to all regardless of socio-economic status or other socio-demographic variables.

Another reason for studying religion in bereaved older adults is that how religion functions or is used by people is most revealing understood when studied in a particular coping context (Pargament, 1997). Not only do the challenges of later life provide one such context but the context of spousal bereavement, which is recognised as one of the most traumatic and distressing life events one can experience, provides a context where perhaps maturity of religious belief faces arguably one of life's most difficult experiences. In these circumstances new insights about how religion functions and is used can be identified. Furthermore, such an approach to researching religion can contribute toward the growing body of research and theorising centred on trying to identify and understand the resources involved in promoting and maintaining the health and psychological well-being of an ever increasing older adult population.

The present thesis consists of four parts and comprises seven chapters. Part 1 provides the theoretical context and background to the present research. Chapter 1 examines the concepts of bereavement, grief, and mourning and reviews the major theories of bereavement and the underlying paradigm shifts involved in explaining the origins and manifestations of grief and the process of coping with bereavement. Chapter 1 also examines the issues and assumptions related to bereavement research with older adults, the physical and mental health consequences of bereavement in later life, and the support for the major theories using older adults. Chapter 2 examines the concepts of religion and spirituality and their conceptual

relationship and reviews the health and ageing research that has been at the vanguard of investigating the influence of religious and spiritual variables. Chapter 2 then reviews in detail the bereavement research to examine the influence of religion and spirituality.

Part 2 consists of two qualitative studies conducted with older adults who have experienced spousal bereavement. Chapter 3 reports the details of Study 1 which was a follow-up study of survivors from a previous longitudinal study of bereavement and personal beliefs by Coleman, McKiernan, Mills, and Speck (2002, 2007). Study 1 aimed to investigate how older adults had coped and adjusted to their bereavement in the longer term since they were last interviewed in 2001 and to explore differences in coping and adjustment based on differences in strength of personal belief (i.e. strong, moderate, and low/no belief). Chapter 4 reports the details of the major qualitative study (Study 2) which focused on a sample of older adults with a strong religious belief that had experienced spousal bereavement. Study 2 aimed to identify the content of religious belief and the religious practice experienced as most important in coping with spousal bereavement and to investigate in what ways this content and practice is related to meaning reconstruction (i.e. sense making, benefit finding, and identity change) thought to be central to grieving (Gillies & Neimeyer, 2006).

Part 3 consists of two preliminary exploratory quantitative studies. Based on the findings from Study 2 that indicated the potentially therapeutic role of religious ritual in coping with spousal bereavement, the construct of religious ritual was theoretically and empirically explored further. Chapter 5 reports the details of Study 3 that begins with a detailed review of the literature on ritual and religious ritual and highlights that religious ritual is an under researched subject in psychology and the wider social sciences. Study 3 aimed to develop, test, and provide preliminary psychometric properties for one of the first scales of its kind to measure importance of religious ritual in one's life that could be used in future research. Chapter 6 reports the details of Study 4 a preliminary study that would use the newly developed religious ritual scale alongside other salient religious and secular variables in a study predicting levels of grief, depression, and anxiety in older adults who had recently lost a spouse.

Finally, in the concluding Part 4 (Chapter 7) an overall discussion is provided for the whole thesis. Chapter 7 reviews the findings of the present research, discusses the findings in the context of salient bereavement theories reviewed in Chapter 1, and highlights observations related to conducting research with religious older adults relevant to theory development in the emerging psychology of religion and spirituality literature. In addition, Chapter 7 discusses the clinical implications of the research, the research limitations, and areas for future research.

PART 1

Chapter 1

The Changing Theoretical Paradigms of Bereavement and Grief Research: Older Adults the Neglected Category

1.1 Introduction

The increase in the world's elderly population along with the prospect that future generations are likely to spend greater proportions of their lifespan in older age has created a need for psychological research to provide a clearer understanding of the factors salient to health and well-being in later life. Part of this need includes understanding how older adults cope with spousal bereavement which is a serious risk to physical and mental health and is an inevitable event for couples entering older age. Therefore, it is perhaps timely that the theories underpinning bereavement and grief research be re-explored.

The present literature review has three main aims: First, to review the key theoretical paradigms used to understand and explain bereavement, grief, and coping with bereavement; second, to highlight how these theoretical paradigms have shifted and changed in their focus in furthering understanding; and third, to identify where possible these theories have been applied to bereavement in older adults. Two secondary aims of this review are to raise awareness of the under recognised severe physical and mental health declines associated with spousal bereavement in older adults, and to draw attention to the misconceptions surrounding bereavement in older age that have hindered research progress. Awareness of these latter issues is necessary in order to appreciate the theoretical paradigms within the wider context of bereavement in later life.

It will be discussed that for much of the 20th Century Sigmund Freud's (1917/1957) psychoanalytic theory was the dominant approach to understanding bereavement and grief, and what was necessary to cope and adjust to a significant loss. However, during the 1980s when bereavement researchers became disappointed with the validity of the psychoanalytic approach a theoretical void opened up with few alternative models available to examine coping with bereavement (Bonanno & Kaltman, 1999). In a bid for new understanding, bereavement researchers turned to a wide variety of often unrelated theoretical paradigms. For example they turned to generic psychological theories (i.e. attachment theory; stress and coping theory); they began to develop new bereavement-specific theories (i.e. tasks of mourning; meaning reconstruction; dual process model); and they embraced theory that emphasised the opposite approach to that of Freud (i.e. continuing bonds). This overall body of theory provides a basis

for understanding the origins and manifestations of grief, grief responses, and coping and adaptation to bereavement.

However the literature review begins with definitions and a discussion of the key research constructs.

1.2 Bereavement, Grief, and Mourning

1.2.1 Bereavement

The terms *bereavement*, *grief*, and *mourning* have often been used interchangeably in the psychological literature, this is predominantly because of their common association with death and loss. However, although there is a certain amount of overlap between the terms, especially between grief and mourning, these terms are not synonyms but have distinctly different meanings.

The term bereavement has been defined as "the objective situation or state of having experienced the death of someone significant in one's life" (Speck et al. 2005, p.146). Within the bereavement literature, research has commonly focused on the irrevocable loss of a significant person such as a spouse, parent, child, sibling, or friend (Stroebe, Hansson, Stroebe, & Schut, 2001). As such, bereavement is almost universally recognised as one of the most distressing and emotionally painful experiences most people will face at some time during their lives. Although bereavement can occur at any time during the lifespan it is most common in older age and often involves the death of a spouse with whom somebody has spent a lifetime (Coleman & O'Hanlon, 2004; Hansson & Stroebe, 2007).

1.2.2 Grief

The term grief, in its most simplistic form, is often defined as the emotional response following a significant bereavement (Speck et al. 2005; Stroebe, Stroebe, & Hansson, 1993). However, in reality the experience of grief is far more complex. Grief consists of a multitude of reactions, some contradictory (e.g. love and anger toward the deceased), that manifest in both intra-personal and inter-personal domains of human functioning (see Table 1 for a summary of grief reactions). In addition to grief being multidimensional, grief is often highly individualised with not all individuals displaying exactly the same reactions, while grief can also vary in duration and intensity between individuals (Shuchter & Zisook, 1993). While early theorists believed that grief lasted for months or up to a year (Engel, 1961; Lindemann, 1944), more recent research suggests that grief can be experienced for several years or even decades,

although grief does show a gradual decline with time in emotional intensity and frequency of thoughts about the deceased (Carnelley, Wortman, Bolger, & Burke, 2006). However, there is also a recognition that some bereaved may not return to "base line" pre-bereaved levels of functioning (Stroebe, Hansson, Stroebe, & Schut, 2001).

Table 1.

Symptoms and characteristics of grief: Grief conceptualised as a complex syndrome.

Domain	Symptoms/Characteristics
INTRA-PERSONAL	
Cognitive	Coincidencing (i.e. seeing signs where none exist), concentration problems, confusion, counterfactual thinking (i.e. imagined alternatives to actual events), denial, derealisation, designation of blame (e.g. self-blame, other blame), existential confusion, lowered self-esteem, identification with deceased, intrusive thoughts, memory problems, preoccupation/rumination about deceased or with death, revenge fantasies, self-reproach, sensing the presence of the deceased, suicidal ideation.
Emotional	Anger, anhedonia, anxiety, depression, dysphoria, fear, guilt, helplessness, irritability, loneliness, mood swings, numbness, post-traumatic stress, repression, sadness, sensitivity, shock, sorrow, specific phobia development, uncontrollability/unpredictability of emotions, yearning.
Behavioural	Agitation, crying, disturbance in impulse control, fatigue, hyper-arousal, lethargy, over-activity, restlessness, searching, tension.
Physical	Exhaustion, reduced immunological and endocrine functioning, loss of appetite, sleep disturbances (e.g. insomnia, early waking), somatic complaints (some similar to the deceased), weight loss.
INTER-PERSONAL	
Social	Isolation, reduced social network, social withdrawal, recklessness or engagement in risky activities.
Relational	Deterioration of relationships with others (e.g. children, relatives, friends, work colleagues), easily irritated by others, reduced productivity at work/school/university.

Note: Table adapted from a similar table used by Hansson and Stroebe (2007).

A further level of complexity has been in the tacit ambiguity in conceptualising grief as a construct that is either medical, psycho-social, or both. Early theorists tended to "medicalize" grief, most notably those from the psychoanalytic schools of the time viewed bereavement as analogous to a serious physical injury that could be treated with therapy, and viewed grief as a potential mechanism integral to mediating the subsequent development of physical illness and psychiatric disorders (Bowlby, 1980; Engel, 1961; Freud, 1926). Indeed, the relationship between grief and illness has a long history. In the Middle Ages grief was linked to the aetiology of mental illness, in the 17th Century grief was recorded as a cause of death, and in the 19th Century opium was used to treat grief (Parkes, 2002). Indeed, more recent theorists have put forward arguments for grief to be considered a disease (Averill & Nunley, 1993; Engel, 1961). As highlighted by Averill and Nunley (1993), not only does grief meet certain medical model disease criteria such as having a known aetiology, being a debilitating condition, and having a relatively predictable prognosis, but also that grief has become an issue for the health and medical professions.

Interestingly, in the contemporary literature, the characteristics of grief have often been inconsistently referred to as *symptoms* denoting indicators of an undesirable disease-related medical condition; and *reactions* or *responses* denoting behavioural indicators to an undesirable psycho-social event. This ambiguity is further exacerbated in recent theorising in which grief has been cautiously labelled a *syndrome* (Averill & Nunley, 1993; Hansson & Stroebe, 2007). Grief as a syndrome has both a medical connotation in which grief is viewed as a group of illness-related symptoms consistently occurring together; and a psycho-social connotation in which grief is viewed as a characteristic combination of emotions and behaviours. In addition, normal progression through grief, with no complications, is sometimes referred to as *healthy grief* and is often contrasted with *pathological grief*. For modern theorists, normal or healthy grief is differentiated from pathological grief primarily by its intensity and duration. In broad terms, grief that is excessively long (i.e. chronic grief) or non-existent (i.e. absent grief), and grief-related emotion that does not appear to subside with time have traditionally been viewed as atypical, problematic, or requiring intervention.

Recent theorists such as Stroebe et al. (2001) have also recognised the underlying medicalization of grief through linguistic indicators such as "symptomatology" to describe grief responses and suggest that this is unhelpful because it turns bereavement into a medical problem or illness. A solely medical conceptualisation is unhelpful to theorists because it understates the psycho-social aspects of grief but is also dangerous for the bereaved who may come to internalise their natural feelings of grief as an illness. Instead, it seems prudent to

consider grief as a *biopsychosocial* construct. This conceptualisation acknowledges the physiological-somatic component of grief and the frequently observed negative impact grief has on health, while simultaneously acknowledging the significant impact grief has on psychological well-being and social functioning. Furthermore, this multidimensional conceptualisation allows grief to be understood and explained from different perspectives.

1.2.3 Mourning

The term mourning refers to the practices and behaviours involved in the expression of grief and are powerfully shaped and sanctioned by social forces such as the culture, customs, and religious traditions of the society to which a person is a member (Speck et al. 2005). Between different cultures the rituals engaged in and the duration of mourning can vary widely. For example, in many Western cultures it is common for mourners to wear black for a short period of time as a sign of sober remembrance and respect for the deceased. In contrast, in Hindu cultures there is the wearing of white during mourning with mourning rituals and practices continuing for up to two weeks (Hansson & Stroebe, 2007). In some Jewish traditions the bereaved may mourn for anywhere between one month and one calendar year before being expected to return to pre-bereaved behaviour patterns (Pollack, 1972). In Japan, Buddhist and Shinto religions with their emphasis on venerating deceased ancestors prescribe the creating of an altar or shrine in the home of the bereaved dedicated to the lost loved one (Yamomoto, Okonogi, Iwasaki, & Yoshimura, 1969). Mourning also has a significant social component and expressions or acts of mourning can function as social indicators that allow other members of a community to know that an individual has recently experienced a significant bereavement, thus increasing the chances of receiving social support. Mourning customs become accepted or established through being internalised over the course of socialisation, while if an individual fails to mourn according to societal norms, for example too little or too much mourning, the individual may meet with the disapproval of other members of a community.

There are also differences in mourning practices depending on age. Younger adults who lose a spouse may be encouraged to mourn for a prescribed period of time and then to consider dating or remarriage, while older adults may be encouraged to mourn open-endly, as traditionally observed in many Catholic countries with elderly widows dressed in black everyday. There may also be age cohort differences in mourning practices. For example, Gorer (1965) noticed how in the mid-1960s older adults engaged in mourning practices left over from the Victorian age, the traditional wearing of black suits or dark dresses, black ties, and the wearing of black arm bands. Interestingly, Gorer (1965) felt that these mourning rituals

were only being kept alive by the oldest members of society. This is in contrast with the mourning practices of the early 21st Century that involve the uploading of obituaries, memorials, and photographs of the deceased onto the World Wide Web (de Vries & Roberts, 2004). Therefore, among contemporary older adults not only will mourning be shaped by the present mourning culture but also by the traditional mourning customs the individual was socialised within.

1.3 Assumptions and Misconceptions about Spousal Bereavement in Older Age

In reviewing the theoretical literature on bereavement and grief a question quickly becomes apparent: Why is there so little theoretical research with bereaved older adults? To which one answer seems to be that there is an underlying assumption that bereavement is less severe in older age, grief is experienced as less problematic, and that older adults are better able to cope, compared with younger adults.

Indeed, within the bereavement literature and ingrained in our culture are a number of assumptions and misconceptions surrounding bereavement in older age. For example, it is widely assumed that because spousal loss is an expected or natural event in older age it is somehow easier to accept than at earlier stages of adulthood (Hansson & Stroebe, 2007; Parkes, 2001). Furthermore, during the transition into older age and because deaths in later life often result from chronic illnesses there is the assumption that individuals will have in different ways anticipated, rehearsed, or prepared for the loss of their spouse (Wolff & Wortman, 2006). Further assumptions are that older adults will have learnt how to cope from their bereaved peers, or even that older adults may be less emotionally reactive to bereavement compared with younger adults (Moss, Moss, & Hansson, 2001; Wolff & Wortman, 2006). There are also lifespan related assumptions which suggest that throughout life older adults will have built up more wisdom, knowledge, and experience in coping with stressful life events, or that the cumulative effect of death-related and role-related losses will have prepared older adults to cope with spousal loss (Baltes & Baltes, 1990; Wolff & Wortman, 2006). There is even the assumption that because older adults have reached older age and may have had a long marriage that they simply have little to grieve about. The accumulation of these assumptions has led to the erroneous belief that the normal course of grief in older adults begins with intense distress or depression that gradually declines with time (Wolff & Wortman, 2006).

Importantly, however, there is almost no empirical evidence to directly support these assumptions, while reviews of the bereavement and ageing literature allow for mixed conclusions to be drawn (Carr, Nesse, & Wortman, 2006; Hansson & Stroebe, 2007). Reviews

examining age as a risk factor for negative bereavement outcome have suggested that bereavement is equally difficult to both younger and older adults alike (Bowlby, 1980; Lund, Caserta, & Dimond, 1993). Other researchers have concluded that younger adults experience more intense grief and are at higher risk of increased mortality and of requiring medical intervention (Hansson & Stroebe, 2007; Parkes, 1996), others still have found that older adults experience more severe grief than younger adults (Sable, 1991).

Despite the mixed conclusions what is clear is that there are a number of factors linked to age-related declines that can exacerbate the experience of spousal bereavement and make coping in older age particularly difficult. For example, in older age there can be a reduction in the network of social support available due to deaths of similar aged peers and the trend for family members to live further away from relatives (Wolff & Wortman, 2006). In older age there can also be a decline in socioeconomic status, with the loss of a spouse in older age further reducing ability to choose living arrangements and ability to maintain the same quality of life (Wolff & Wortman, 2006). Declines in health and the increase in chronic illness in older age may also reduce ability to live independently and diminish perceived ability to cope. In addition, many older adults who lose a spouse may have been married for decades and will have built up interdependencies, roles, and a shared identity making adjustment to bereavement even more difficult (Moss, Moss, & Hansson 2001). The married relationship may have been central to daily routines, traditions, and habitual ways of thinking and behaving, and the loss may cause feelings of disorganization and loneliness, while the loss of an attachment figure may reduce perceived meaning and purpose in life. Moreover, if older adults perceive that their marriage was unhappy or filled with regrets they may feel they have much to grieve about because the opportunity to make amends is gone. Also, the increased likelihood of experiencing significant losses in later life could lead to bereavement overload that may further undermine ability to cope (Moss et al. 2001).

In summary, spousal bereavement is likely to be equally as distressing for both younger and older adults, but may have different consequences for each age group. For example, in younger adults the untimeliness of an early bereavement is likely to be viewed a tragedy with the loss causing discord in the continuity of life of the surviving spouse and ending or disrupting future aspirations (Hansson & Stroebe, 2007; Parkes, 1996; Wolff & Wortman, 2006). For older adults bereavement may result in more practical problems such as longer periods of time spent in isolation, involuntary relocation, and needing assistance with daily living. Bereavement may also cause older adults to reflect on their life negatively and may be involved in Erikson's (1963) theorising on the concept of despair in later life. Conclusions

about age differences in bereavement suggest that younger adults may experience initially greater intensity of grief but that older adults will experience a protracted course of grief accompanied by increased depression and physical health problems (Archer, 1999; Parkes, 1996; Sanders, 1981).

1.4 Bereavement and Physical Health

A number of studies have shown that compared with non-bereaved older adults the loss of a spouse in older age is associated with a range of physical health problems. For example, bereaved older adults report experiencing more severe physical pain (Bradbeer, Helme, Yong, Kendig, & Gibson, 2003); report more illness symptoms (Thompson, Breckenridge, Gallagher, & Peterson, 1984); suffer more physical limitations and need more physical assistance (Goldman, Korenman, & Weinstein, 1995); make more visits to doctors or hospitals (Prigerson, Maciejewski, & Rosenheck, 2000); show a decline in immune system functioning (Hall & Irwin, 2001); and show an increase in heart disease (Carr, 2001, cited in Pienta & Franks, 2006). Most seriously, research has shown that older adults who lose a spouse have higher rates of mortality (Bowling & Windsor, 1995; Gallagher-Thompson et al. 1993; Goodkin et al. 2001; Hansson & Stroebe, 2007; Stroebe & Stroebe, 1993) with the most severe risk of mortality occurring within the first year of bereavement and with males being at heightened and prolonged mortality risk than females (Christakis & Iwashyna, 2003; Lichtenstein, Gatz, & Berg, 1998; Schaefer, Quesenberry, & Wi, 1995).

According to Wolff and Wortman (2006) part of the explanation for the increase in mortality may be in the higher rates of suicide in bereaved older adults (Erlangsen, Jeune, Bille-Brahe, & Vaupel, 2004; Harwood, Hawton, Hope, Harriss, & Jacoby, 2006a; Harwood, Hawton, Hope, & Jacoby 2006b; Li, 1995) and in the disruption or change in healthy lifestyle routines and the increase in negative health behaviours following spousal bereavement (Umberson, 1987, 1992; Umberson, Wortman, & Kessler, 1992). For example, bereaved older adults show an increase in excessive alcohol (Bowling, 1987; Byrne, Raphael, & Arnold, 1999; Perreira & Sloan, 2001) and tobacco use (Bowling, 1987; Pienta & Franks, 2006), experience disrupted or reduced sleep and insomnia (Foley, Monjan, Simonsick, Wallace, & Blazer, 1999; Reynolds et al. 1992), and experience a decrease in dietary intake of nutrients (Quandt, McDonald, Arcury, Bell, & Vitolins, 2000; Rosenbloom & Whittington, 1993; Wilcox et al. 2003).

The association between bereavement and physical health has contributed toward bereavement being viewed within a medical model whereby grief is considered a medical

problem that can be alleviated with pharmacological treatment. It is not uncommon for physicians to prescribe minor tranquillisers, sleeping pills, and anti-depressants (with or without counselling depending on resources) to those experiencing bereavement. Indeed, research has shown that bereaved older adults use more prescription medication compared with their married counterparts (Charlton, Sheahan, Smith, & Campbell, 2001; Pienta & Franks, 2006).

1.5 Bereavement and Mental Health

In addition to physical health problems, spousal bereavement in older age is also associated with a number of mental health problems. Perhaps unsurprisingly one of the most robust findings is that compared with non-bereaved older adults, those who have lost a spouse show higher levels of depression (Byrne & Raphael, 1999; Carnelley, Wortman, & Kessler, 1999; Carr, House, Wortman, Nesse, & Kessler, 2001; Turvey, Carney, Arndt, Wallace, & Herzog, 1999), while analysis by gender reveals that bereaved men experience higher levels of depression than bereaved women (Lee, Willetts, & Seccombe, 1998; van Grootheest, Beekman, Broesse van Groenou, & Deeg, 1999), and that the young-old (65-74 years) may be at more risk of developing chronic depression following spousal bereavement than the old-old (75-99 years) (Mendes de Leon, Kasl, & Jacobs, 1994). However, research also suggests that depression does decline with time since bereavement over a two year period (Hansson & Stroebe, 2007).

In addition, bereaved older adults, compared with married age-matched controls, also show an increase in anxiety that can remain elevated for anywhere between 13 months to eight years post-bereavement (Bennett, 1997a, 1997b; Byrne & Raphael, 1997). Other studies have shown that older adults who lose a spouse can meet the criteria for post-traumatic stress disorder within the first six months post-bereavement (Elklit & O'Connor, 2005), and can experience disturbing intrusive thoughts (Byrne & Raphael, 1994), and both social and emotional loneliness (van Baarsen, van Duijn, Smit, Snijders, & Knipscheer, 2001-2002). In a separate line of research spousal bereavement in older adults has also been associated with cognitive declines related to memory and attention performance on neuropsychological tests (Aartsen et al. 2005; Ward, Mathias, & Hitchings, 2007; Xavier et al. 2002). Finally, with regard to overall coping, Wolinsky and Johnson (1992) have found that bereaved older adults are twice as likely as non-bereaved older adults to become institutionalised, specifically during the second year of their bereavement when the demands of coping may become overwhelming.

1.6 Theoretical Approaches to Understanding Bereavement and Grief

The review of the theoretical literature is grouped into two main parts. The first part focuses on general theories of grief including psychoanalytic theory; attachment theory; and continuing bonds. The second part focuses on theories of coping and adaptation including stress and coping theory; stage, phase, and task theories; meaning reconstruction; and the dual process model.

1.7 General Theories of Grief

The general theories of grief, specifically the psychoanalytic approach and attachment theory, explain the underlying origins and manifestations of grief responses but also speak to issues of coping with bereavement. The theory of continuing bonds takes a position opposite to the psychoanalytic approach and speaks more explicitly to the ongoing process of cognitive adaptation.

1.8 Psychoanalytic Theory

For most of the 20th Century the dominant approach to understanding bereavement and grief was the psychoanalytic approach most notably represented by the theorising of Sigmund Freud. Freud (1917/1957) had a considerable interest in "Trauer" the German word meaning both grief and mourning (Strachey, 1957) and dedicated much of his theorising and time to understanding the workings of these processes. Indeed, Freud's earliest recorded theorising on grief and mourning has been traced as far back as January, 1895 in private letters written to colleagues, and spans right up to the publication in 1917 of Freud's seminal paper *Mourning and Melancholia* (Strachey, 1957).

Freud (1917/1957), through his clinical observations, noted significant differences between what he termed mourning (i.e. the normal course of grief) and melancholia (i.e. pathological grief). At a superficial level Freud noted that the characteristics unique to melancholia and which separated it from normal mourning was severe self-reproach and ambivalence for the lost loved one. However, at a deeper psychological level Freud developed a complex theory to explain the manifestation of these differences that was based on the ideas of *libido* (energy of the life instincts), *cathexis* (investment of libido energy), and incorporated what would later come to be recognised as object-theory (pioneered by Klein). Freud theorised that when an individual forms a strong attachment to a person (an "object" which is separate and outside of oneself) they unconsciously engage in cathexis - the investment of psychic

libidinal energy on to the desired person. However, when the object, or person in the case of bereavement, is no longer available grief serves the function of motivating the individual to sever attachments with the lost person and detaching libidinal energy so that it can be reinvested in another person. The process of detachment of energy has since come to be known as *grief work*, a cornerstone of bereavement and grief theorising, that can be traced back to the translated phrase used by Freud "the work which mourning performs" (p.244).

According to Freud (1917/1957), in normal mourning, grief work involves reality-testing and confronting that the deceased loved one no longer exists. In describing "the work of mourning", Freud wrote "each single one of the memories and expectations in which the libido is bound to the object is brought up and hypercathected [additional energy invested], and detachment of the libido is accomplished in respect of it" (p.245). Although Freud is laconic in describing the details of grief work, the interpretation that has become widely endorsed is that each of the cognitive and emotional links associated with the deceased need to be brought to attention and re-examined over a period of time so that the relationship with the deceased can be relinquished ready for new intimate relationships to be formed (Bonanno, 2001). Supporters of the grief work approach have suggested that absence of grief work would be detrimental to physical and mental health and would result in a delayed grief response (Bowlby, 1980; Middleton, Moylan, Raphael, Burnett, & Martinek, 1993). One of Freud's conclusions on normal mourning was that the loss of interest in life, difficulty sleeping, and loss of appetite observed in the bereaved could be explained by the ego and remaining libidinal energy being so absorbed in the process of grief work that there is little energy left over for other activities.

In the case of pathological mourning, as mentioned above, Freud (1917/1957) suggested that the normal process of detachment can be complicated as a result of at least two related processes: identification with the lost loved one and ambivalence felt toward the lost loved one. Freud proposed that in the case of identification, the underlying (or unconscious) wish of part of the ego is to maintain the attachment to the deceased and not to experience the loss. Freud described a process whereby energy is withdrawn from the deceased into the ego but is not reinvested in another person but instead displaced on to the part of the ego that has identified with the deceased in an attempt to consume and possess them forever. As a result, the loss is not experienced as the loss of a loved one but as the loss of part of the ego, and because this "work of melancholia" is conducted in the unconscious provided an explanation for why Freud's bereaved patients themselves could not understand their own grief reactions.

Similarly with regards to ambivalence, Freud (1917/1957) proposed that for whatever subjective reason both love and hate is experienced toward the deceased and results in a similar

unconscious desire not to detach invested energy. Freud believed that ambivalence caused a conflict within the ego whereby one part of the ego seeks to detach from the deceased while another part seeks to maintain the attachment. However, through the repression of ambivalence in the unconscious the bereaved are prevented from fully understanding their grief. Hence for Freud this provided the explanation that the often observed self-reproach demonstrated in melancholia is not really aimed at the self but is actually aimed at the lost loved one which has become part of the ego. Indeed, Freud's own ambivalence felt towards his father is well documented, especially the case of Freud being late for his father's funeral, an example of his unconscious anger toward his father, which has since served to emphasise the subtle yet powerful influence of ambivalence on behaviour during mourning (Carver & Scheier, 2000).

Thus, according to Freud (1917/1957), whereas normal mourning takes place in the unconscious but can easily pass to pre-conscious and conscious, pathological mourning takes place in the unconscious and is held there by *anticathexis* – libidinal energy used to repress threatening information. Furthermore, suicide or suicidal ideation as a consequence of experiencing bereavement was for Freud an example of self-reproach being so severe as to react against the life instinct (Eros), and further confirmed some of Freud's later theorising about the death instinct or Thanatos complex in human beings.

Within bereavement and grief theorising, Freud's (1917/1957) psychoanalytic theory has received probably more criticism than any other theory, with criticism focusing primarily on Freud's emphasis that grief work was necessary and essential for healthy or optimal grief outcome. Indeed, it has only been relatively recently, since the publication of the influential paper *The Myths of Coping with Loss* by Wortman and Silver (1989) that highlighted how little empirical research was available to evaluate the theory, have researchers begun to examine the validity of grief work. Since the late 1980s the majority of empirical research (using non-elderly participants) has either failed to find support for the theory (Bonanno & Keltner, 1997; Stroebe, Stroebe, Schut, Zech, & van der Bout, 2002) or has found only partial support (Stroebe & Stroebe, 1991).

In the context of older adults there has been almost no empirical research dedicated to examining the claims of grief work making it difficult to draw firm conclusions. What research is available provides minimal or no support for grief work. For example, research by Segal, Bogaards, Becker, and Chatman (1999) offers some support that grief work may have a small beneficial effect on grief outcome. In their emotion disclosing task designed to be similar to confronting grief, Segal et al. (1999) had 30 bereaved older adults (mean age 67 years) assigned to either an emotion disclosing group whereby participants were asked to talk about the loss of

their spouse and express their grief during four 20-minute sessions over a two week period or a delayed-treatment control group. Immediate post-treatment results showed that emotion disclosing older adults showed no difference in measures of distress, depression, or intrusive/avoidant thoughts, compared with controls, however, older adults who disclosed emotion did show lower levels of hopelessness. Although the study had several methodological limitations (e.g. a small sample size, short duration of emotion disclosing intervention) it did suggest that some grief characteristics in older adults may be reduced by confronting and disclosing emotion. In contrast, longitudinal research by Boerner, Wortman, and Bonanno (2005) has found that bereaved older adults who initially showed minimal grieving when first bereaved (akin to no grief work) did not develop mental or physical health problems or show a delayed grief response up to 48 months post-loss but actually adjusted better to spousal bereavement than older adults who reported higher levels of grieving.

An additional criticism related specifically with ageing in mind is that when grief work is applied to older adults some elements of the theory seem to conflict with well-established theories of ageing detailing the emotional and behavioural preferences in the elderly (c.f. Socio-emotion selectivity theory, Carstensen 1991; Carstensen, Isaacowitz & Charles, 1999). For example in grief work suggesting that the bereaved should detach energy from their deceased spouse in order to reinvest energy in "new" relationships seems to conflict with theories of ageing that suggest in older age there is a reduced interest in starting new relationships, and there is a greater reliance on and preference for familiar emotional or social partners (Coleman & O'Hanlon, 2004). Indeed, many bereaved older adults articulate that they feel they could never begin a new romantic relationship following the loss of their spouse for feelings of being disloyal to the memory of their spouse and for fear of experiencing bereavement again. Several studies have shown that older adults, particularly widows, seldom remarry following spousal bereavement and that there can also be a lack of potential partners to start new intimate relationships (Bowlby, 1980; Lopata, 1996; Lund, Caserta, & Dimond, 1993; Parkes, 1996).

In addition to theoretical criticisms, there are also a number of methodological and linguistic criticisms related to grief work that deserve consideration when evaluating this theory. Grief work was not well defined by Freud (1917/1957) and as highlighted by several researchers has proven difficult to operationalise in research testing grief work predictions (Stroebe, 1992; Stroebe & Schut, 2001; Stroebe & Stroebe, 1991). Similarly, the use of the metaphor "grief work" by Freud's earliest followers (e.g. Deutsch, 1937; Lindemann, 1944) has proven to be something of a misnomer and exacerbated some of the ambiguity surrounding the theory and contributed toward the perception that Freud was oversimplifying the process of

grief. In fact on reading Freud's original text it is clear that Freud is describing a lengthy and often painful psychological process; however some of Freud's original details seem to have been lost over the decades through summaries of his work being condensed for publications. At the most basic linguist level it has also been proposed that some of Freud's original emphasis and detail has been lost in translation (Bettelheim, 1982).

An additional area of criticism has been in Freud's (1917/1957) methodology in developing his theory. Carver and Scheier (2000), in reviewing Freud's psychoanalytic approach, discuss a litany of methodological limitations and biases that may dramatically reduce the generalisability of Freud's theorising. Of particular note is that a lot of Freud's theorising was based on a small number of clinical cases (which is something Freud himself admitted with regard to grief work). According to Carver and Scheier (2000), Freud's observations were probably based on a dozen or so case studies. Furthermore, Carver and Scheier (2000) highlight that the clinical cases reported were not chosen at random but in fact that Freud was highly selective in who was accepted for therapy and subsequently described. In addition, in his dual role as therapist-researcher, Freud was probably highly directive in what retrospective material was discussed while simultaneously patients may have succumbed to demand characteristics (Orne, 1962) and acquiesced in giving Freud the material they believed he was interested in (Carver & Scheier, 2000).

Nevertheless, despite the criticisms and limitations there continues to be great interest in Freud's (1917/1957) grief work theorising amongst both lay people and bereavement researchers alike, while the principles of grief work are still central to much bereavement counselling and therapy (Stroebe et al. 2002). A mark of the recognition of grief work is the fact that after over 90 years since original publication, bereavement researchers are still debating the validity of Freud's ideas and new theories are being proposed specifically in response to Freud's theorising (e.g. see theory of Continuing Bonds below).

1.9 Attachment Theory

One of the most important theoretical paradigms in explaining the behavioural, emotional and cognitive phenomenology of grief and mourning has been John Bowlby's (1969, 1973, 1980) attachment theory. Although Bowlby's attachment theory was originally developed to explain infant-caregiver behaviour and developmental psychopathology, in his later works Bowlby shifted the focus of his theory to explaining grief and mourning in adulthood. Although Bowlby's attachment theory can be seen as a reaction against the prevailing dominance of the psychoanalytic schools of the time, Bowlby developed and refined

his theory of attachment over several decades and was influenced by a number of scientific fields besides psychiatry. For example, attachment theory is influenced by Charles Darwin's theories on natural selection and the expression and function of emotion; by Konrad Lorenz's ethological theories including those on imprinting; and by one of Bowlby's own supervisors, Melanie Klein's theories on childhood mourning and object theory.

The underlying principle of attachment theory is that through natural selection all infants have developed an innate attachment behavioural system. This is a motivational system designed to encourage and maintain a close proximity between the infant and the primary caregiver (i.e. the attachment figure), and to reduce any prolonged separation from the caregiver. For Bowlby (1980), the behaviours elicited in response to prolonged separation from the attachment figure (e.g. protest, yearning, searching, pining, anger) are the result of an inbuilt evolutionary system activated in response to separation that in our evolutionary past would have promoted survival and enhanced reproductive fitness. However, most importantly with regard to bereavement, was that Bowlby theorised that the separation behaviours observed in infancy were similar to behaviours in adults experiencing grief and mourning in response to a significant bereavement.

Bowlby (1980) demonstrated what he considered "variations on a single theme" (p.76) in response to loss in his seminal book entitled *Attachment and Loss: Sadness and Depression*. Bowlby (1980), drawing primarily on interview data by Parkes (1970), and Glick, Weiss, and Parkes (1974) of bereaved adults aged between 26 to 65 years, identified that following the loss of a spouse the bereaved pass through a sequence of four phases. First there is initial *numbness* in response to the loss interrupted by moments of intense often overwhelming emotion which usually lasts for hours up to a week. Numbness is followed by *yearning and searching* for the deceased that can last for months or years and includes a realisation of the reality of the loss and is often accompanied by feelings of anger. This phase is followed by *disorganization and despair* in which habitual patterns of thinking and behaving established prior to bereavement are perceived as redundant and no longer meaningful leading to depression and apathy. However, for Bowlby these negative feelings were seen as necessary in encouraging realisation that one's life, self, and situation need to be modified. This realisation results in the final phase of *reorganization* in which the bereaved begin to take on new tasks and a new identity as a widow. Although acknowledging individual differences between the bereaved in oscillating back and forth between phases, Bowlby suggested that this overall sequence represented a normal or "healthy" progression through grief and is observed in the majority of bereaved adults.

As well as explaining normal responses to loss, Bowlby (1980) also identified a dichotomy in atypical variants of grief that deviate from normal grief responses. In discussing disordered variants of healthy mourning, Bowlby differentiated between two main types of atypical grief that could be conceptualised as lying along a grief response spectrum. At one end of the spectrum, "chronic mourning" whilst at the opposite end "prolonged absence of conscious grieving", with normal grief lying somewhere between the two extremes (Bowlby, 1980, p.138).

For Bowlby (1980) chronic mourning was principally characterised by persistent depression lasting from anywhere between several months to several years after the loss. Depression was often accompanied by recurring episodes of anxiety in the form of generalised anxiety, agoraphobia, or hypochondria. Individuals may also experience self-reproach, anger, and a preoccupation with thoughts about the deceased or aspects of the loss (e.g. symptoms of the lost partner's medical condition). Bowlby (1980) also considered excessive alcoholism to be associated with chronic mourning. As a result of these characteristics, individuals are unable to easily return to pre-bereaved levels of functioning. In contrast, a prolonged absence of grief was principally characterised by a noticeable absence of distress or depression, and a continuation with day-to-day activities (e.g. work, social activities) as if no bereavement had happened.

More recently, Bowlby's (1980) theoretical dichotomy of chronic mourning and absence of grief has received support. Middleton, Raphael, Martinek, and Misso (1993) report a survey they conducted that found a high proportion of contemporary bereavement theorists and clinicians agreed with this distinction. Furthermore, Bowlby's distinction can encompass a number of overlapping grief subtypes identified by theorists and clinicians. Bowlby's description of absence of grieving can encompass *delayed grief* (Parkes, 1965) the absence of symptoms of grief for a prolonged period of time more than two weeks; *inhibited grief* (Parkes, 1965) the inability or unwillingness of the bereaved to talk about, acknowledge, or express emotion (e.g. cry) about the loss; and *absent grief* (Deutsch, 1937) a total absence of external signs of grieving, denial of grief, and a continuation with everyday activities as if the loss had not occurred. Also, Bowlby's description of chronic mourning can encompass *unresolved grief* (Zisook & Lyons, 1990) characterised by unchanging distress, depression, and withdrawal persisting for years after the loss.

Most importantly with regard to bereavement, is that Bowlby (1980), and the attachment theorising that has followed him, has attempted to make connections between atypical forms of grief in adulthood and insecure attachment behavioural patterns in infancy.

Fraley and Shaver (1999), drawing on the classic Strange Situation laboratory procedure by Mary Ainsworth, one of Bowlby's former trainees, that involves a series of infant-caregiver separation and reunion episodes (see Ainsworth, Blehar, Waters, & Wall, 1978), have identified how chronic mourning behaviour in adults appears similar to behaviour in infants classified as anxious-ambivalent. During separation episodes of the Strange Situation, anxious-ambivalent infants tend to be overtly focused on the whereabouts of their attachment figure, cry continuously, and when the attachment figure returns cannot easily be consoled, that for Fraley and Shaver (1999) represented an embryonic form of the intense and prolonged distress observed in chronic mourning. In addition, behaviour observed in adults of an absence of grief has been compared with infants classified as insecure-avoidant in response to separation. Avoidant infants, during separation episodes, tend to display few external signs of distress, continue to play with toys, and ignore their attachment figure on return, that for Fraley and Shaver (1999) represented a miniature form of the absence of distress and ability to continue with daily activities observed in absent grief.

Fraley and Shaver (1999) provided further support for a link between atypical forms of grief and insecure attachment by drawing on the adult attachment literature involving responses to relationship break-ups and divorce. Research using the Adult Attachment Interview (Main, Kaplan, & Cassidy, 1985), a clinical assessment instrument designed to measure an adult's present state of mind regarding attachment experience during infancy, has identified two relevant insecure adult attachment styles, namely *preoccupied* and *dismissing*, that correspond closely with chronic and absent grief, respectively. Research examining adult romantic break-ups has identified that those with a preoccupied adult attachment style respond to relationship break-ups with extended periods of crying, distress, anxiety, and show a desire to cling to partners, that for Fraley and Shaver (1999) is similar to both anxious-ambivalent patterns in infancy and chronic mourning behaviour following a significant bereavement. Furthermore, those classified as dismissing tend to respond to relationship break-ups with relatively little distress or protest about the separation, and show few signs of yearning for their absent partner, that for Fraley and Shaver (1999) is similar to avoidant attachment patterns in infancy and absence of grief in response to a significant bereavement.

One of the strengths of attachment theory in relation to grief is that it provides a theoretical explanation about the mechanisms underlying responses to brief separation in infancy that may also apply to responses to permanent loss in adulthood. According to attachment theory, variations in normal and atypical responses to bereavement in adulthood are the result of how early attachment figures are represented in internal working models, and how

the behavioural and emotional attachment system has become organised to respond during interactions with primary caregivers in early infancy and childhood. Adults who respond to a significant bereavement with chronic grief may have internal working models of unresponsive or insensitive attachment figures and may have emotional and behavioural attachment systems organised around enhancing the potential of receiving attachment behaviour. These behaviours may include hypervigilance toward attachment cues, protesting, searching, clinginess, and inability to concentrate on other activities (Fraley & Shaver, 1999). Those who exhibit absence of grief may have internal working models of rejecting or dismissing attachment figures, and have attachment systems organised around suppressing or denying elements of their loss, and that encourage a focus on emotional and behavioural independence or self-reliance (Fraley & Shaver, 1999). In contrast, attachment theory would suggest that those who have a normal progression through grief have internal working models based on responsive and sensitive attachment figures, and are confident in their ability to confront and manage their loss, and have confidence in the ability of others to offer support. Therefore, in essence, according to Bowlby (1980), attachment representations, behaviours, and emotions that are established during infancy to real or symbolic losses (e.g. separation) can be primed or activated in adulthood in response to a significant bereavement.

However, recent reviews of attachment among older adults (Bradley & Cafferty, 2001), and attachment theory in bereavement in older age (Hansson & Stroebe, 2007), have both highlighted that there has been almost no empirical research carried out to examine the role that infancy attachment patterns or adult attachment styles have on coping with bereavement in later life. However, what minimum research there is with older adults provides some support that secure attachment is more closely related to lower levels of grief than insecure attachment. Research by Sable (1989) using 81 bereaved older widows (median age 63 years) found that those who self-reported secure infant attachments showed less grief and anxiety to the loss of their husband compared with widows with anxious attachments. Furthermore, widows who reported being highly dependent on their husband, similar to high levels of dependency seen in anxious-ambivalent infants toward attachment figures, showed greater levels of grief, fear of being alone, and depression, compared with less dependent widows. Similar findings have also been reported by Parkes (2002) with non-elderly adults. Using retrospective accounts of infancy attachment, Parkes (2002) found that bereaved adults who described an anxious-ambivalent attachment to parents displayed prolonged grief and dependent behaviour, while those who described an avoidant attachment reported difficulty in expressing their grief. Furthermore, those who described a disorganised/disoriented attachment (a third insecure

attachment pattern identified by Main & Soloman, 1990, associated with family violence or rejection) following bereavement displayed anxiety, panic, depression, excessive alcoholism, and self harm (Parkes, 2002).

Although for many bereavement and attachment researchers the accumulated attachment findings with children and adults have been used to support predictions that infant attachment patterns shape adult responses to bereavement, these attachment findings still need to be confirmed with bereaved older adults. In Chapter 6, Study 4, the influence of adult attachment style on bereavement outcome in recently bereaved older adults will be investigated alongside other salient variables.

1.10 Continuing Bonds

The theory of continuing bonds as put forward by Klass, Silverman, and Nickman (1996) in their influential book *Continuing Bonds: New Understandings of Grief* marks the most significant paradigm shift in bereavement and grief research. Their book made explicit what had up to that time been an underlying discontent with traditional theories of bereavement, and legitimised the paradigm shift from modern to post-modern approaches to theory and methodology in bereavement and grief research. At the centre of this paradigm shift was the emphasis on viewing the resolution of grief not from detachment of the bond felt toward the deceased as put forward by Freud (1917/1957), but by a maintenance and enhancement of the bond felt toward the deceased. In addition, in outlining their theory of continuing bonds, Silverman and Klass (1996) offer one of the most comprehensive critiques on Freud's (1917/1957) theory of grief work. As such, the theory of continuing bonds can be viewed as the diametric opposite of Freud's detachment approach that for Klass et al. (1996) is outdated and unhelpful. Instead, continuing bonds emphasises the variety of cognitive, emotional, and behavioural processes that the bereaved actively use in maintaining a relationship (or attachment) with the deceased and that are experienced as helpful in coping and adjustment.

For Klass et al. (1996) the idea of detachment from the deceased was not only counterproductive by exacerbating the trauma of bereavement but was actually the opposite of what the bereaved seem to need and actually engaged in during coping. Working with their respective participant groups, Klass et al. identified several similarities between parents coping with the death of a child, children coping with the death of a parent, and adopted children adapting to learning their adoptive status within surrogate families. Klass et al. reported that bereaved children and adults described coping involving continuing a relationship with their

deceased loved ones through thinking about the deceased; dreaming about the deceased; talking to the deceased; believing the deceased was watching them; sensing the presence of the deceased; hearing the voice of the deceased; and perceiving the influence of the deceased in events in their personal world, and on their decision making and behaviour. In the case of adoptees grieving for a retroactive loss, they described constructing an internal representation of their deceased parent who they had never known and having an internal relationship including internal dialogues that influenced their behaviour.

However, for Klass et al. (1996) the robustness of these findings could not be explained within a detachment model of grief and did not fit with what they had been taught to expect during their clinical training about coping involving severing bonds with the deceased. Instead, Klass et al. concluded that these grieving participants were adaptively changing the nature of their connection to the deceased and continuing a perceived relationship, and that because the deceased loved one was on some level still a part of their ongoing life this seemed to facilitate coping and adjustment.

In discussing the dominance of the grief work model, Silverman and Klass (1996) highlight that for most of the 20th Century the role of continuing bonds in normal grieving has been ignored, minimised, or most often considered a pathological sign of unresolved grief, wishful thinking, or denial that is detrimental to coping and grief resolution. In arguing against the validity of the grief work approach, and indirectly supporting their own theory of continuing bonds as a normal and legitimate process in grieving, Silverman and Klass (1996) make three powerful points. First, is that Freud's personal experiences of bereavement later in his life indicate that Freud himself may not have agreed with his own theory written earlier in his career. Second, is that within the psychoanalytic theory there are a number of examples of continuing bonds which have been misrepresented as pathological. And third, is that data demonstrating the role of continuing bonds in coping has been identified several times over the decades but has never been given theoretical form.

Silverman and Klass (1996) cite how Freud, nine years after the death of his daughter Sophie, wrote a private letter to a friend who had recently lost his own son, in which Freud seems to contradict his original grief work theory. In contrast to Freud's (1917/1957) early theory of grief which stated that the bereaved should detach energy from the deceased so that energy can be reinvested in another person, in practice Freud actually appeared to advocate a maintaining of the relationship to the deceased. In his letter Freud wrote: "Although we know that after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be

filled completely, it nevertheless remains something else. And actually this is how it should be. It is the only way of perpetuating that love which we do not want to relinquish (E. L. Freud, 1960, p.239 cited in Silverman & Klass, 1996, p.6).

In addition, further incongruence between theory and theorist emerges after the death of Freud's grandson age four years. Jones (1957), a biographer of Freud's life and work, recounts: "It was the only occasion in his life when Freud was known to shed tears. He told me afterwards that this loss had affected him in a different way from any of the others he had suffered. They had brought about sheer pain, but this one had killed something in him for good…A couple of years later he told Marie Bonaparte that he had never been able to get fond of anyone since that misfortune, merely retaining his old attachments; he had found the blow quite unbearable, much more so than his own cancer" (Jones, 1957, p.92 cited in Silverman & Klass, 1996, p.6-7).

Thus, for Silverman and Klass (1996) these revealing personal accounts of Freud's own bereavement experiences provided evidence that Freud himself was aware that the process of grieving was not to detach energy invested in a loved one so that it could be reinvested in a new person, but that Freud recognized the importance of maintaining an attachment to the deceased. However, because Freud never gave theoretical form to his personal experiences subsequent generations of psychoanalytic thinkers built their grief theorising on Freud's earlier writings on detachment and reinvestment of energy.

Silverman and Klass (1996) further argue that the psychoanalytic concepts of internalization, introjection, and identification which, although having differences in precise meaning, collectively describe the mental processes involved in absorbing the deceased and the relationship with the deceased into mental representations, by their very nature can be reinterpreted as basic examples of continuing bonds. Furthermore, the concept of hypercathexis, used by Freud (1917/1957) to describe the additional energy invested in the deceased as a prelude to severing the bond and represented as a preoccupation with thoughts about the deceased, can also be reinterpreted as a form of continuing bonds. Although these processes were viewed within the grief work model as pathological defences that inhibited healthy present-oriented relationships and were too unchangeable, static, and inaccessible to conscious control to be of any benefit, Silverman and Klass (1996) suggest that their data with bereaved children, parents, and adoptees demonstrated that these inner representations are not unconscious but accessible and develop with the maturational needs of the individual. Indeed, Silverman and Klass (1996) highlight that more recent psychoanalytic theorists have articulated

how the ego can be enriched through the process of continuing bonds by the individual taking on the desirable characteristics of the deceased.

Silverman and Klass (1996) discuss that early bereavement research repeatedly identified continuing bonds processes but interpreted these findings within the dominate bereavement models of the time, namely grief work and attachment theory. Thus, furthering knowledge about the variety and range of grief responses but preventing a full understanding of the role of maintaining a bond with the deceased during coping. For example, Silverman and Klass (1996) cite the research of Parkes and colleagues (e.g. Glick, Weiss, & Parkes, 1974; Parkes, 1972, 1975a, 1975b; Parkes & Brown, 1972; Parkes & Weiss, 1983) who during the 1970s and 1980s in their interview studies with bereaved adults identified continuing bonds processes such as sensing the presence of the deceased, visualizing the deceased, and hearing the voice of the deceased. However, these processes were interpreted within an attachment framework as ethological mechanism elicited in response to separation from an attachment figure that facilitate search behaviours. Silverman and Klass (1996), however, demonstrate that the persistence of continuing bonds processes throughout the research by Parkes and colleagues did eventually lead Bowlby (1980) in his later theorising to modify his theories on mourning to acknowledge that continuing bonds processes could be experienced as helpful in adjustment and that they did not lend support to Freud's (1917/1957) emphasis on the necessity of detachment.

For Silverman and Klass (1996) the resilience of the grief work model is based on how human relationships have come to be viewed in modern Western society but does not represent the grief practices of previous generations or other societies (see Klass & Walter, 2001; Stroebe, Gergen, Gergen, & Stroebe, 1996). In modern Western society relationships serve the purpose of meeting instrumental needs and when relationships no longer satisfy these needs they can easily be ended and the individual is free to move on to more fulfilling relationships. For Silverman and Klass (1996) the grief work model also reflects Western society's emphasis on how separate and individualistic people are from one another whereby independence and personal autonomy are considered desirable and valued characteristics and dependency and co-operation are considered undesirable or undervalued. Silverman and Klass (1996) highlight that in bereavement research, especially within attachment paradigms, characteristics such as dependency have become pathologized, with some bereavement theorists considering dependency a risk factor for pathological grief (e.g. Parkes & Weiss, 1983; Raphael, 1983). Thus, according to Silverman and Klass (1996) a key feature that differentiates grief work from continuing bonds is that the former views people as independent within relationships and

possessing a finite amount of energy to be invested within a restricted number of instrumentally purposeful relationships. The latter views people as interdependent and able to function in a multitude of physical, mental, and emotional relationships at a time whether the other party is present or deceased (Silverman & Klass, 1996).

According to Silverman and Klass (1996) the grief work model also reflects the values of logical positivism with its emphasis on objectivity and detachment. For Silverman and Klass (1996) logical positivism is not value free but designed to confirm the assumptions of dominant models or groups and to reduce or distort dissenting observations in to something near unrecognizable within these models. Also, that within logical positivism the emphasis is on measuring observable behaviour and therefore subjective experiences involving internal relationships with others and how people make meaning of these relationships are minimized or dismissed. Silverman and Klass (1996) suggest that in bereavement and grief research the grief work model and the logical positivistic approach of modernity should be replaced by post-positivistic methods more suited to a post-modern world. Furthermore, that future research should use qualitative methods better suited for understanding subjective states, interpretations, and experiences central to how individuals make meaning in their relationships and bonds, and to identify the rituals, practices, and resources that help the bereaved to maintain a connection with the deceased (e.g. religious beliefs and practices).

However, there are a number of significant limitations with the theory of continuing bonds. For example, there is no clear definition for continuing bonds, and there is no demarcation for what constitutes continuing bonds processes and what is simply rumination, reminiscence, or imagination. At present, it appears as though almost any thought, emotion, or behaviour related to the deceased that encourages positive coping and adjustment can be interpreted as a continuing bonds process. In addition, there is little empirical research to indicate a difference between insecure pre-occupation with the deceased and continuing bonds, and no criterion for what counts as a healthy or unhealthy bond, other than a healthy bond should not hinder normal everyday functioning or adjustment to bereavement.

With regard to elderly populations, continuing bonds has not been fully explored in bereaved older adults (but see Chapter 4, Study 2). Interestingly, in two recent books reviewing bereavement research on older adults (i.e. Carr, Nesse, & Wortman, 2006; Hansson & Stroebe, 2007) there is a noticeable absence of continuing bonds theory and research. However, a number of interview based studies with bereaved older adults who have lost a spouse provide some support that certain continuing bonds processes such as talking to the deceased, dreaming of the deceased, and sensing the presence of the deceased are helpful to coping (Bennett &

Bennett, 1999; Bennett, Hughes, & Smith, 2005; Coleman, McKiernan, Mills, & Speck, 2002, 2007; Golsworthy & Coyle, 1999; Moss & Moss, 1996).

In summary, the theory of continuing bonds changes the way the relationship with the deceased is perceived, and changes the way bereavement outcome is evaluated. From a continuing bonds perspective, concepts such as closure, resolution, letting go, and recovery used to describe an endpoint in bereavement outcome are inappropriate (Silverman & Klass, 1996). From a continuing bonds perspective there is no time limit to grief, the intensity of grief-related emotions may decrease with the progress of time but the process does not end. Instead, the individual is changed forever by the bereavement experience and the relationship to the deceased does not end but becomes transformed into something new. For Silverman and Klass (1996) the term most suited to describe the process of continuing bonds in coping is *accommodation*. This process involves a continual and ongoing process of psychological adaptation whereby perceptions of the self, of the deceased, and the relationship become modified to meet the demands of the grief being experienced at a particular time. Accommodation allows the loss to gradually be incorporated into the larger life schema or narrative of the individual and allows the meaning of the loss and the relationship with the deceased to be renegotiated with time as the coping experience unfolds.

1.11 Theories of Coping and Adaptation

The ideas of accommodating bereavement within larger cognitive schemas and renegotiating the meaning of the loss are themes that are central to both generic and bereavement-specific models of coping with a significant bereavement, and are examined more closely in the following sections on coping and adaptation.

1.12 Stress and Coping Theory: Defining Coping and Adaptive Coping Strategies

The stress and coping theory pioneered by Lazarus and Folkman (1984) is a generic theory of coping developed to explain the underlying cognitive processes involved in coping with a range of stressful events, from everyday hassles to major life traumas (Folkman, 2001). This theory is relevant to bereavement research for at least two important reasons. First, it provides a clear definition of coping and an explanatory model of the coping process (see Figure 1); and second, it provides several theory-based categories of coping strategies (e.g. problem-focused versus emotion-focused; confrontation versus avoidance) that can be applied to coping with the stress of bereavement.

Coping is defined as "the person's cognitive and behavioural efforts to manage (reduce, minimize, master, or tolerate) the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the resources of the person" (Folkman, Lazarus, Gruen, & De Longis, 1986, p.572). As can be seen in Figure 1, following a potentially stressful event, the process of coping begins with the individual appraising the subjective significance of the event as threatening, harmful, or challenging. Secondary appraisals may also involve evaluating options for coping and can be influenced by one's beliefs, goals, or resources (Folkman, 2001; Park & Folkman, 1997). The process of appraisal can affect whether positive or negative emotions are experienced, and influences what cognitive, emotional, or behavioural strategies will be engaged in to manage personal distress caused by the event and to cope with the event itself (Folkman, 2001).

The most widely recognised category of coping strategies is known as problem-focused versus emotion-focused (Folkman & Moskowitz, 2004). Problem-focused coping involves strategies that directly deal with or attempt to resolve the problem causing distress, for example following spousal bereavement learning to perform the tasks previously carried out by the deceased spouse (e.g. finances, home maintenance, cooking, shopping). In contrast, emotion-focused coping involves strategies that attempt to reduce or minimise the negative or unpleasant emotions caused by the problem, for example engaging in distracting activities to suppress worries about not being able to perform the tasks formerly carried out by the deceased spouse. According to stress and coping theorists, problem-focused coping is most appropriate for stressors that are changeable, while emotion-focused coping is appropriate for stressors that are unchangeable (Hansson & Stroebe, 2007; Lazarus & Folkman, 1984). Thus, strictly speaking, it could be argued that only emotion-focused coping applies to bereavement as bereavement involves an irrevocable loss. However, as demonstrated by the above example problem-focused coping can be aimed at directly managing post-bereavement stressors.

An additional and similarly useful category of coping strategies involves confrontation versus avoidance (Hansson & Stroebe, 2007). As applied to bereavement, confrontation would involve strategies that encourage acceptance and realisation of the loss, for example the bereaved may visit the cemetery where the deceased is buried or begin giving away personal items belonging to the deceased. In contrast, avoidance strategies are those that may attempt to protect or shield the bereaved from the reality of the loss, strategies involving denial, suppression, or disengagement. For example, the bereaved may avoid emotionally-charged reminders of the deceased or avoid talking about the bereavement.

According to the stress and coping model (see Figure 1), if strategies are successful in managing the event, a favourable outcome is reached, positive emotion is experienced, and the overall effect of the event should produce little stress. However, if strategies engaged in are unsuccessful in managing the demands of the event, an unfavourable or no resolution is reached and distress is experienced, leading to coping (re)appraisals of the event occurring.

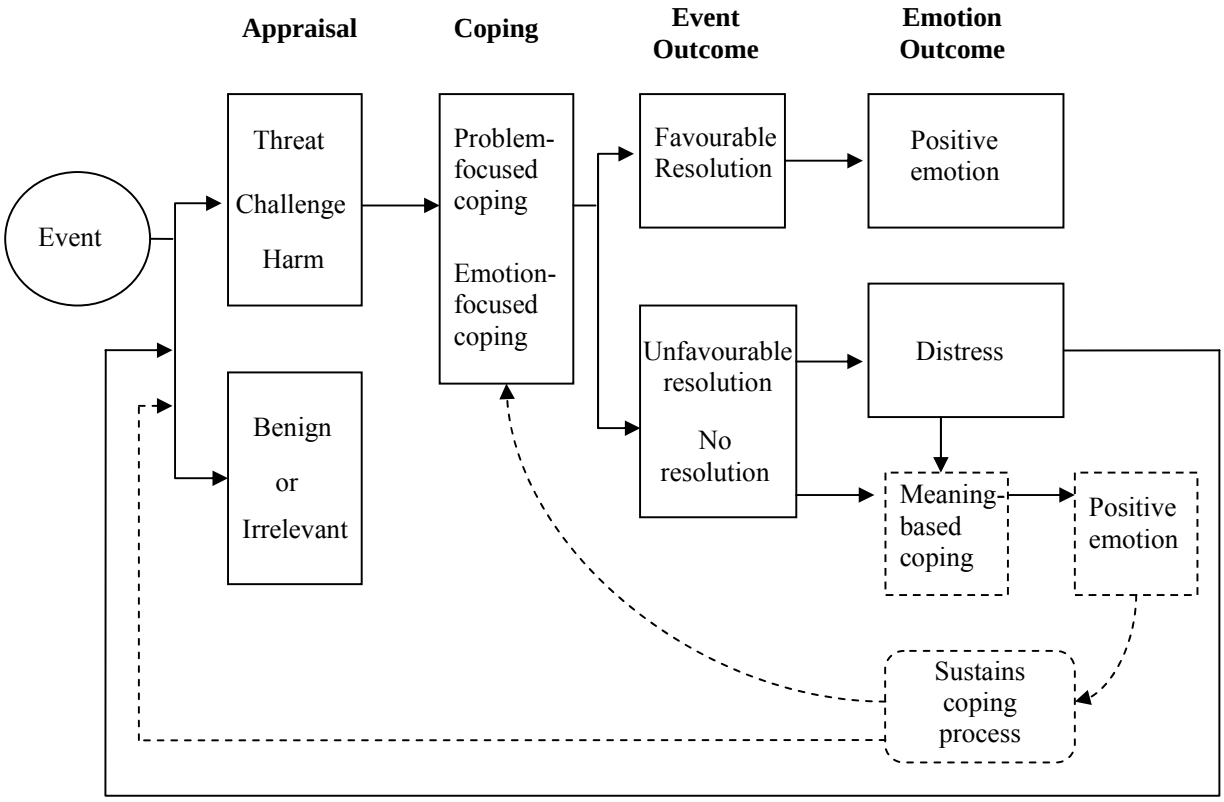


Figure 1. Original Stress and Coping Model (Folkman, 1997). Revised Version (Folkman, 2001). Additional components of revised version marked by dashed boxes/lines.

However, as pointed out by several researchers (e.g. Folkman, 2001; Hansson & Stroebe, 2007) the stress and coping model outlined by Lazarus and Folkman (1984; Folkman, 1997, 2001) is a process-oriented theory only - that is it describes the process of coping, and therefore makes few assumptions about which strategies will bring about a desirable or optimal outcome. For this reason Hansson and Stroebe (2007) have suggested that in bereavement research it is necessary to define strategies that do have an effect on bereavement outcome. They propose use of the term *adaptive coping strategies* to describe those coping processes that can lower grief and reduce or ameliorate the negative biopsychosocial consequences resulting from bereavement. Implicit to this conceptualisation is that only some coping strategies will be

beneficial in both the short and long term, other strategies may have no beneficial properties, while others still may even be harmful (Hansson & Stroebe, 2007).

Similar to strategies used within the stress and coping model, adaptive coping strategies used may vary as the coping process unfolds (Folkman, 2001; Hansson & Stroebe, 2007). For example, following spousal bereavement emotion-focused strategies such as being in the company of others may be useful in the immediate aftermath in preventing loneliness, while problem-focused strategies such as taking additional employment to compensate for loss of income caused by spousal bereavement may be valuable in the longer term. In addition, the efficacy of different coping strategies may be complicated by the time course and multidimensionality of grief. For example, an avoidant strategy such as denial may have an apparent beneficial effect in the early stages of grief by blocking out the emotional pain of bereavement but may be harmful in the longer term by preventing the person from cognitively accepting the loss. Furthermore, an avoidant strategy such as suppression at the level of grief-related emotion may increase the likelihood of intrusive thoughts about the loss at the cognitive level.

Recently, Folkman (2001) has revised the stress and coping model based on longitudinal research with gay caregivers of men with AIDS who became bereaved during the course of the five year study (the additions to the revised model are represented by dashed boxes/lines in Figure 1). During interviews, bereaved caregivers often articulated coping characterised by high levels of positive emotion simultaneously with negative emotion. Caregivers also articulated the importance of meaning-making processes in helping them cope, while quantitative measures of meaning-making independently accounted for significant unique variance in positive affect after controlling for psychosocial variables including social support, optimism, and health (Folkman, 2001). The content of meaning-making processes primarily involved positive reappraisals of self-worth, of increased wisdom and strength developed, of life lessons learned from the bereavement experience, and of gaining a new perspective on life and death. Interestingly, Folkman (2001; see Richards & Folkman, 1997) also found that religious and spiritual beliefs were spontaneously mentioned as supporting positive affect two to fours weeks after bereavement and encouraged existential meaning to be found related to the death of their partner (see Chapter 2 for an in-depth discussion about the role of religion and spirituality in bereavement).

Folkman (2001) revised the coping model accordingly to accommodate for the adaptive function of meaning-making processes and positive emotion during the coping process (see Figure 1). Folkman's (2001) revised model now explained that through chronic unfavourable

or no resolution outcomes and distress there becomes a need to experience positive affect (even if only momentarily as in the case of respite) that motivates meaning-making processes to encourage positive emotion which in turn sustains coping (re)appraisals and the entire coping process. The importance of Folkman's (2001) revised model is that it shows how negative psychological states can lead to a search for and creation of meaning in stress and that the function of meaning-making processes may be to maintain coping with a chronic stressor (like bereavement and grief) for an indefinite period. We return to the subject of meaning-making in bereavement later in the chapter (see section 1.14).

Although the theorising about the coping process and adaptive coping strategies is useful in bereavement research, with regards to bereavement outcome, as pointed out by Folkman (2001) and Hansson and Stroebe (2007), the process of coping should be seen in context with other potentially important factors. For example, factors such as the cause of death or the suddenness of the death may also play a role in overall "recovery" or adjustment. However, the process of coping and adaptive coping strategies are important because within the often uncontrollable circumstances of bereavement, coping and coping strategies used are something that the bereaved may have control over and can also be targets for intervention by bereavement therapists and counsellors (Folkman, 2001).

In summary, stress and coping theory deserves special mention because this explanatory theory and model has guided much bereavement thinking about coping and provided bereavement research with a lexicon of coping strategies and coping terminology. Stress and coping theory highlights the mediating role of cognitive (re)appraisal and meaning-making processes, which may be especially salient in coping with bereavement whereby the effectiveness of problem-focused strategies may be perceived as reduced. These processes can also account for individual differences in bereavement coping and outcome. Furthermore, the theory also emphasises the motivational role of both positive and especially negative emotions in coping and adjustment. However, the model is not without its limitations. One significant limitation highlighted by Hansson and Stroebe (2007) is that the model was designed to explain coping with one stressor at a time while in bereavement there can be multiple stressors. As will be discussed, this problem has been resolved in bereavement-specific models of coping that have been influenced by the stress and coping model (see section 1.15).

1.13 Stage, Phase, and Task Theories

One of the most widely recognised and earliest theoretical approaches associated with bereavement and grief research has been the stage and phase theories. These theories, informed

largely by interview data, have attempted to describe the sequence of cognitive and emotional processes (referred to temporally as phases or stages) that the bereaved voluntarily or involuntarily pass through from initial distress to adaptation and recovery.

Since the 1960s there have been a number of different versions proposed that involve a varying number of discrete or overlapping stages/phases, some involving three stages (Shuchter & Zisook, 1993), four stages (Marrone, 1999), six stages (Rando, 1993) and up to nine stages (Ramsay & de Groot, 1977). However, perhaps the most influential of these stage theories has been the version proposed by Kübler-Ross (1969). According to this theory the bereaved progress through five stages during grief, namely: denial, anger, bargaining, depression, and acceptance.

Although this theory has been widely accepted by bereavement theorists and clinicians and is still taught in medical schools in understanding adaptation to bereavement, it is noteworthy that Parkes (2002) highlights how Kübler-Ross's (1969) theory was designed to explain the phases through which terminally ill patients experience the process of dying not grief, and was based on interviews with over 200 terminally ill patients. Kübler-Ross (1969) developed her theory from the earlier theorising about the sequence of phases the bereaved pass through by Bowlby and colleagues (Bowlby & Parkes, 1970). Kübler-Ross's (1969) theory only became associated with the grief process in an article entitled *The Dying Patient's Grief* in 1963 by Knight Aldrich, a former professor of Kübler-Ross (Rothaupt & Becker, 2007).

Despite this theoretical discrepancy and regardless of the varying number of stages discussed in different individual models that have been proposed over the decades, Weiss (1993) has suggested that every stage/phase theory of normal grief follows a similar general pattern or sequence. The bereaved begin by denying the loss yet consciously acknowledge and recognise what has transpired. The loss is then perceived as temporary and attempts are made to change the situation. The permanent nature of the loss is then reluctantly accepted and depression and hopelessness are experienced. Gradually, depression and hopelessness are replaced by hope or optimism that a satisfying life can still be lived.

In addition, Weiss (1993) suggests that in the process of moving toward adaptation or recovery every stage or phase theory involves transitions related to three underlying processes: cognitive resolution involving the development of a subjectively satisfying account of the bereavement; emotional acceptance involving adjustment to affectively charged memories that when recalled can be overwhelming; and identity change involving the development of a new sense of self oriented toward the present with the attachment to the deceased placed in the past (Weiss, 1993).

Despite the fact that stage and phase theories, especially those of Bowlby (1980) and Kübler-Ross (1969), have been known about and used in therapy and counselling settings since the 1960s, surprisingly there has been almost no empirical research to examine their validity. As discussed by Wortman, Silver, and Kessler (1993) part of the difficulty in testing these theories has been rooted in the claims made by their authors that the bereaved are able to experience more than one phase or stage at a time, can oscillate between stages, and can even skip stages. It is only recently that the theoretical claims of these models have been examined. In a longitudinal study of recently bereaved middle-aged and older adults, using a synthesis of the stages by Bowlby (1980) and Kübler-Ross (1969), Maciejewski, Zhang, Block, and Prigerson (2007) found that the sequence of grief stages progressed over the first 24 months post-loss as follows: disbelief, yearning, anger, depression, and acceptance. Furthermore, that each negative stage peaked within the first six months post-bereavement while acceptance increased throughout. Thus, this research has provided some support that the stages of grief do exist.

Although the heuristic quality of stage and phase theories has been popular with bereavement theorists, therapists, physicians, and lay people, in providing an indicator of what series of responses are likely to be experienced during grief, this theoretical approach has received much criticism. For example, stage and phase theories offer little in the way of explanation about the variety of bereavement responses and individual differences in grief observed, including differences in grief intensity and duration. Also, this approach provides little explanation about the reason for and development of pathological grief, or how bereavement influences physical and mental health problems and the increased risk of mortality (Wortman et al. 1993).

An additional criticism is that the perceived prescriptive accounts of grief offered by this theoretical approach may actually be counterproductive for those coping with grief as often the stages and phases are interpreted too literally (Worden, 2002). Although many of the theorists stated that their theories provided a general descriptive guide to grief, many relatives, friends, and even counsellors of the bereaved can come to develop erroneous expectations about the correct course, progression, and duration of grieving. Similarly, the bereaved can become overly concerned about whether their grieving is correct or normal which can exacerbate the distress being experienced.

For Worden (2002), a psychotherapist, a more suitable approach to understanding adaptation to bereavement than stages or phases is viewing adaptation as requiring the completion of a series of cognitive and emotional tasks. For Worden the idea of the bereaved

passing through phases on the way to adaptation appeared too passive, while the idea of stages was too rigid and deterministic. Instead, Worden, based on his clinical experience and analysis of the grief literature, proposed his tasks of mourning theory that focused on adaptation to grief involving the bereaved actively engaging in and completing the following four tasks: to accept the reality of the loss; to work through the pain of grief; to adjust to an environment in which the deceased is missing; and to emotionally relocate the deceased and to move on with life (Worden, 2002). According to Worden, these tasks could be fluidly revisited and completed in any order and could take months or years to complete, any longer and intervention to facilitate completion of these tasks may be necessary.

Although these tasks have much in common with Freud's (1917/1957) grief work approach with their emphasis on confronting the reality of the loss and grieving involving "work", Worden's (2002) tasks of mourning theory underwent a shift in emphasis consistent with the acceptance of continuing bonds with the deceased that was becoming apparent in the wider bereavement and grief theorising of the time. Evidence of this shift is that in the 1982 first edition of Worden's influential book *Grief Counselling and Grief Therapy*, the fourth task of his theory was for the bereaved to withdraw emotional energy invested in the deceased and to reinvest it in another relationship. However, by the second edition in 1991 the fourth task was changed to emphasise the bereaved emotionally relocating the deceased in their ongoing life, while by the fourth edition in 2009 Worden fully advocates the bereaved developing an enduring continuing bond with the deceased as his fourth task, with the bereaved finding ways to memorialise the deceased.

It should be noted that the tasks of mourning theory was developed to guide the thinking of those working with or treating the bereaved rather than in providing empirically testable hypotheses. As such, the validity of the theory has not been empirically examined. Rather the tasks of mourning theory emphasises the processes that can be targeted by clinicians to help facilitate the bereaved in being able to live a meaningful life again.

1.14 Meaning-Making and Meaning Reconstruction

The idea that meaning-making processes can play an integral or mediating role in coping has received increasing attention in recent years within bereavement theorising. A relevant influence on the thinking in this area has been Vikor Frankl's (1962/1984) seminal book *Man's Search for Meaning*. Frankl believed that a primary motivating factor in all humans is to find meaning and purpose in life, over and above other psychological motives such as desires for pleasure or power as proposed by Freud and Adler respectively. Informed

by his own research and his experience as a survivor of the concentration camps during the Second War World, Frankl argued that if meaning could be found in a traumatic situation then coping could be enhanced and the trauma could be transcended or survived. The theorising of Frankl has been considered in coping with the trauma of bereavement.

Within bereavement and grief theorising the role of meaning-making processes are often framed within the context of what is cognitively disrupted by bereavement. Janoff-Bulman (1989, 1992) and colleagues (Janoff-Bulman & Berg, 1998; Janoff-Bulman & McPherson, 1997; Schwartzberg & Janoff-Bulman, 1991; see also Parkes, 1971) have theorised that people possess what are known as *assumptive worlds*, these are fundamental assumptions or cognitive schemas that people rely on to understand and make sense of the world. Three particularly salient assumptive worlds are that the world is a benevolent place; the world is meaningful and what happens to us makes sense; and the self is worthy (Fleming & Robinson, 2001; Janoff-Bulman, 1992; Stroebe & Schut, 2001). Although these assumptive worlds normally go unchallenged in everyday life the experience of a major trauma such as a significant bereavement can shatter these assumptions causing severe existential distress that can leave the bereaved feeling that the world is a malevolent, meaningless, or unpredictable place, and that they have little ability to cope or reason to trust.

Cognitive adaptation to bereavement is proposed to involve a gradual rebuilding of less-threatening assumptions that can accommodate the loss and encourages the bereaved to perceive the world as a benevolent and meaningful place again and that they are able to cope. The process of rebuilding assumptions involves searching for meaning in the loss, positive reappraisals or interpretations of the loss, and identifying benefits or life lessons learned from the event (Janoff-Bulman, 1992). An optimal outcome would involve a re-establishment of meaning in life with the bereaved possessing both old and new assumptions about themselves and the world.

More recently, Neimeyer (2001, 2002, 2006) and colleagues (Gillies & Neimeyer, 2006; Neimeyer, Baldwin, & Gillies, 2006) have built on the ideas of Janoff-Bulman (1992) in their theory of meaning reconstruction that details the meaning-making processes central to assimilation and accommodation of bereavement. This theory views individuals as the authors of their own self-narratives or autobiographies that have a coherent and meaningful structure about one's identity, experiences, and aspirations. A trauma such as bereavement can disrupt or disorganise the structure and continuity of one's self-narrative forcing the bereaved to revise and repair their life narrative to incorporate the loss (Neimeyer, 2006). The process of

reconstructing meaning in one's self-narrative has been proposed in a model by Gillies and Neimeyer (2006), see Figure 2.

The model suggests that people possess a number of core meaning structures known as pre-loss meaning structures similar to Janoff-Bulman's (1992) assumptive worlds that refer to fundamental assumptions or beliefs important to understanding one's life. According to the model, a significant bereavement can be either consistent or inconsistent with pre-loss meaning structures. When a loss is consistent and can be explained or understood using pre-loss meaning structures little distress is experienced and no modification is needed to pre-existing meaning structures.

In contrast, when a loss is considered inconsistent and cannot be assimilated using pre-loss meaning structures there is an increase in distress. In an attempt to reduce distress the bereaved engage in a search for meaning related to the loss which involves three meaning making processes that come to embody meaning reconstruction, these processes are: sense making, benefit finding, and identity change (see section 4.1.4 for a more detailed discussion of these individual processes). Through engagement in these three processes pre-loss meaning structures are reviewed and reconstructed in order to accommodate the loss. Through the process of meaning reconstruction new post-loss meaning structures become established that allow the bereaved to perceive their loss, their life, and the world in new ways (Gillies & Neimeyer, 2006). If post-loss meaning structures are helpful in decreasing distress they may form the basis for new fundamental assumptions or schemas about the world, however if post-loss meaning structures are unhelpful the process of meaning reconstruction will continue (Gillies & Neimeyer, 2006). Through the process of meaning reconstruction and developing new ways of perceiving the world the bereaved can experience a new sense of self or personal growth (Gillies & Neimeyer, 2006; Hogan, Greenfield, & Schmidt, 2001).

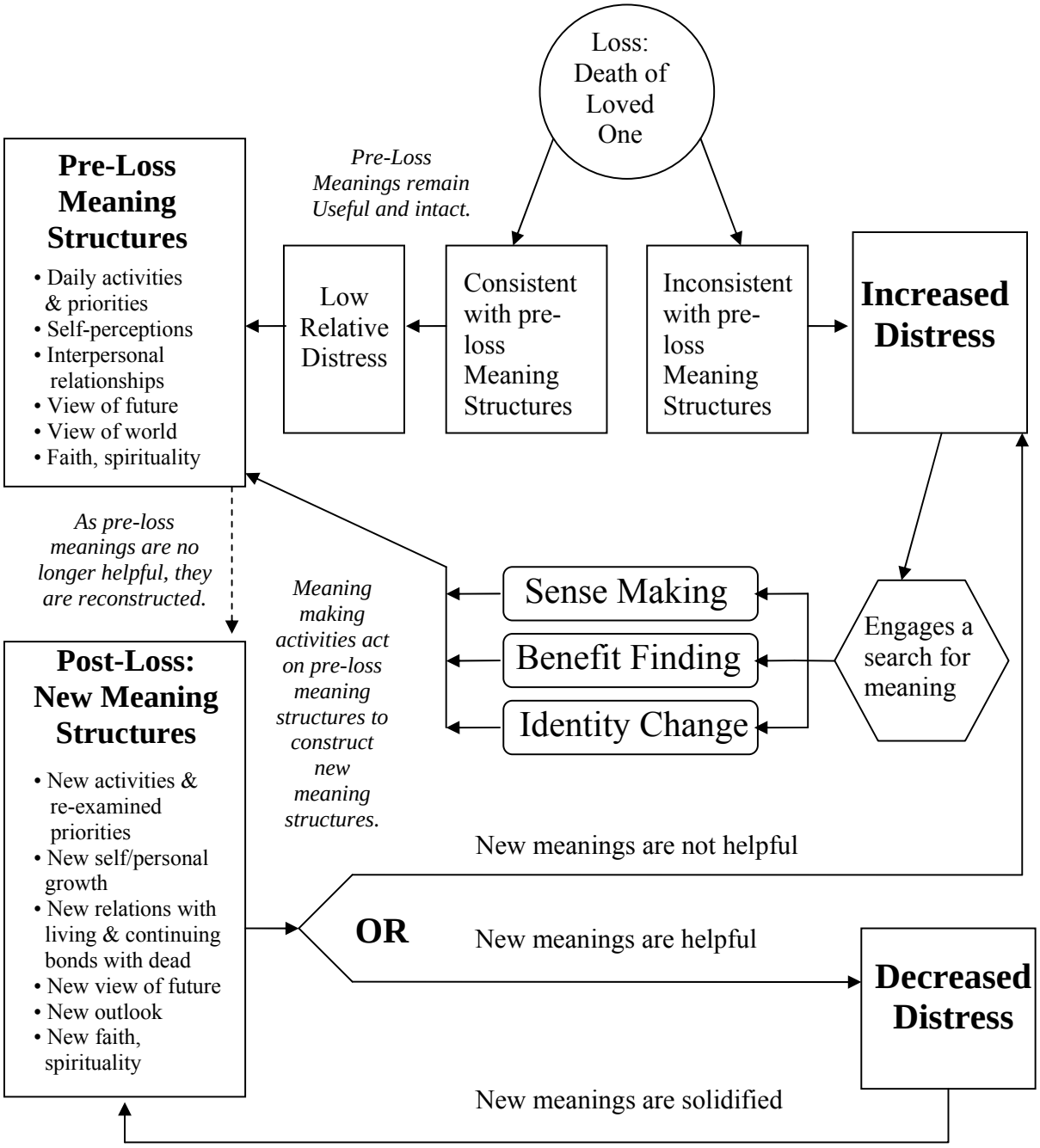


Figure 2. Model of Meaning Reconstruction in response to bereavement (Gillies & Neimeyer, 2006).

As this is a relatively new model empirical support is still limited, however Neimeyer, Baldwin, and Gillies (2006) do offer some support. Using young adults who had experienced a range of bereavements, Neimeyer et al. (2006) found that meaning reconstruction (sense making, benefit finding, identity change) predicted better grief outcome compared with continuing bonds with the deceased which was associated with increased grief. Furthermore, meaning reconstruction moderated the influence of continuing bonds on grief whereby under

high meaning reconstruction conditions continuing bonds were no longer related to increased grief. With regard to research with older adults, meaning reconstruction is yet to be investigated. In Chapter 4, Study 2 the role of religious belief in meaning reconstruction is examined with bereaved older adults.

1.15 Dual Process Model

The Dual Process Model (DPM; Stroebe & Schut, 1999, 2001) represents an attempt to integrate existing bereavement and grief theoretical approaches within one unified theory of coping. Developed specifically to explain coping with bereavement from a partner, the model proposes that successful adaptation involves oscillating coping between two distinct categories of bereavement-related stressors (see Figure 3). The *loss orientation* refers to coping primarily with the stress associated with the loss of a significant attachment figure, while the *restoration orientation* refers to coping with the secondary stressors that are a consequence of the bereavement.

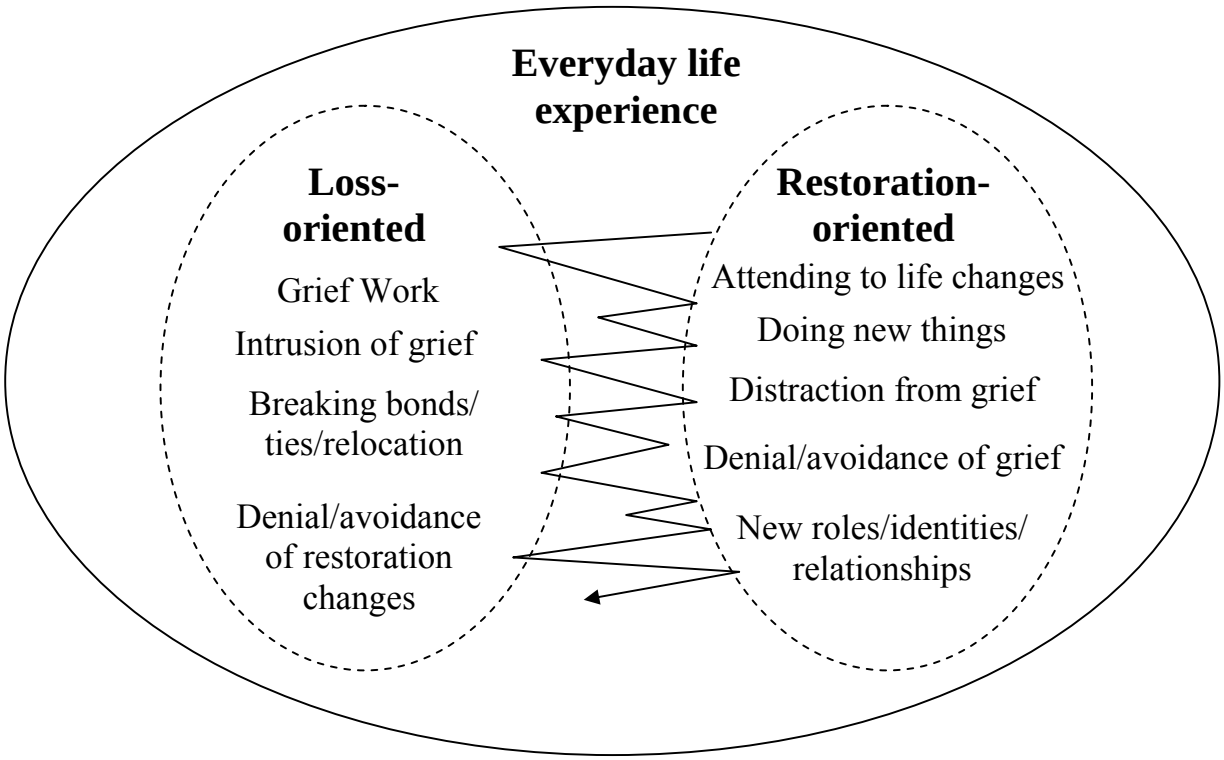


Figure 3. The Dual Process Model of coping with bereavement (Stroebe & Schut, 1999).

Hansson and Stroebe (2007) suggest that during the early stages of grief there may be an emphasis on loss-oriented stressors. The loss orientation involves the bereaved focusing on some aspect of the loss of a loved one itself and can facilitate coping by helping the bereaved to

adjust to the reality of the loss and the intensity and variety of grief-related emotions. Loss-oriented processes may include ruminating on events related to the loss, thinking about the relationship with the deceased, questioning aspects of the bereavement, and searching for meaning in the loss. According to Hansson and Stroebe (2007) although during loss-oriented coping negative emotions predominate, with time positive emotions are increasingly experienced, for example as fond memories related to the deceased are recalled during episodes of reminiscence. Furthermore, in contrast to stage and phase theories that suggest different emotions will be experienced in a set linear sequence, Hansson and Stroebe (2007) suggest that during loss-oriented coping both positive and negative emotions will fluctuate moment-by-moment both within a single day and throughout the course of grief. In essence, the loss orientation is proposed to account for processes related to the theories of grief work, attachment, continuing bonds, meaning reconstruction, rebuilding assumptive worlds, and tasks of mourning (Hansson & Stroebe, 2007).

As the grief process progresses the bereaved may shift their attention from focusing on loss-oriented stressors to restoration-oriented stressors (Hansson & Stroebe, 2007). The restoration orientation involves the bereaved focusing on the secondary psycho-social implications resulting from bereavement which are anxiety provoking and can exacerbate the stress being experienced. Secondary stressors may involve having to learn the jobs or roles previously performed by the deceased spouse (e.g. household chores, home maintenance, cooking, shopping, finances). Also, adjusting to living alone, developing new daily routines and habitual ways of thinking, and adjusting to the new status of widow/widower instead of wife/husband. In addition, in the context of older adults there may be additional stressors involving assessing whether one can still live independently or whether moving to more manageable accommodation is necessary. Similar to the loss orientation, Hansson and Stroebe (2007) suggest that both positive and negative emotions will be experienced during restoration-oriented coping. For example, the bereaved may feel anxiety or fear about the prospect of having to manage by oneself while at the same time may experience a sense of achievement at accomplishing new tasks (Hansson & Stroebe, 2007). For Hansson and Stroebe (2007) the restoration-oriented coping processes of identifying and appraising whether the secondary implications of bereavement are likely to be stressful are similar to processes related to Lazarus and Folkman's (1984) stress and coping model. However, unlike the stress and coping model that focuses on coping with one stressor at a time during the coping experience, the DPM focuses on coping with multiple stressors (Hansson & Stroebe, 2007).

For Hansson and Stroebe (2007) long term adjustment to bereavement requires the ability to oscillate between coping with loss and restoration-oriented stressors. According to Hansson and Stroebe (2007), oscillation is essential to coping because the bereaved cannot focus on loss-oriented and restoration-oriented stressors simultaneously. Therefore, oscillation allows the bereaved to confront and avoid certain stressors at different times. Sometimes the bereaved will concentrate on grieving for the deceased while at other times the bereaved will engage in activities that distract them from their grieving (e.g. being with friends, attending church, watching television).

One of the strengths of the DPM is that the process of oscillation, which acts as a regulatory mechanism orchestrating coping, can account for coping differences between normal and pathological grief styles. Whereas in normal grieving the bereaved are thought to find a balance in oscillating between loss and restoration-orientations, in pathological grieving there is too little oscillation (Hansson & Stroebe, 2007). For example, in the case of chronic grieving (also anxious-ambivalent/preoccupied attachment style) there may be too much of a focus only on loss-oriented stressors, while in absent grief (also avoidant/dismissing attachment style) there may be too much of a focus on restoration-orientated stressors (Hansson & Stroebe, 2007). Thus, for Hansson and Stroebe (2007) there needs to be a balance in oscillating between the orientations and that too much of a focus on just one orientation will not lead to optimal or healthy bereavement outcome.

Although the DPM has yet to be fully tested, recent research with bereaved older adults does offer some limited support for the model. For example, Utz (2006) and Richardson and Balaswamy (2001) have found that both loss and restoration-oriented dimensions are important throughout the grief process (see also Chapter 3, Study 1, for similar findings). In addition, Richardson (2007) has shown that loss-oriented activities such as visiting the cemetery were more important in the early stages of grief while restoration-oriented activities such as socialising with others became more important with increasing time since bereavement.

1.16 Summary

In summary, there is a paucity of research on spousal bereavement in older adults; part of this neglect may be attributed to scientific and societal assumptions associated with bereavement in older age. Findings from several studies provide convincing evidence about the detrimental consequences of bereavement to physical and mental health in older age, however much less is known about potential protective factors. Very little of the research with older adults has been linked to the key theories of bereavement, grief, and coping. Instead, for the

majority of research, the relevance of the findings to specific theories has often been left to the reader to establish.

The major theoretical paradigm shift has been from Freud's (1917/1957) psychoanalytic approach with its emphasis on severing cognitive and emotional attachments with the deceased, to a continuing bonds approach (Klass et al. 1996) with its emphasis on maintaining an attachment with the deceased. The DPM goes some way toward accommodating both perspectives within one model through the process of oscillation. In addition, underlying this shift is a scientific and philosophical movement from a procrustean, mechanistic paradigm that enforces conformity and views people as resolving their grief with little or no variation or individuality, to a paradigm that respects individual differences and views people as resolving their grief through being the authors of their own self-narratives, and influenced by subjective states and personal meaning.

Related paradigm shifts have included viewing resolution of grief as being set by fixed, unchangeable attachment patterns and a passive, deterministic progression through a series of stable grief stages, to active engagement in individualistic appraisal of bereavement and reconstruction of subjective meaning. Also, from viewing bereavement as culminating in solely negative emotion and a series of personal declines, to acknowledging the capacity to experience positive emotion and personal growth.

Importantly, while early theories had no place for the role of personal coping resources such as religious belief and practice, the most recent and influential theories (i.e. continuing bonds, meaning reconstruction, and the DPM) have arrived at a position whereby they have the potential to include these protective coping processes. The role of religion in bereavement, health, and ageing research is examined in the next chapter.

Chapter 2
Religion and Spirituality in Health, Ageing, and Bereavement

2.1 Introduction

Throughout human history, religion in its various forms has been one of the most powerful motivating forces in human civilisation, inspiring creative and destructive thoughts and behaviours, shaping ethics and laws governing individual and societal standards and norms, and influencing the formation and cohesive running of institutions and societies.

More recently, in Britain and Western Europe, the latter half of the 20th Century has witnessed a gradual decline in religious affiliation and church attendance. Although some social commentators have seen this decline as part of the long prophesied demise of religion in the technological west, there can still be observed a continuing public interest in issues related to religion and spirituality. Interest in religion and spirituality can be seen for example in the media attention surrounding the threats from religious inspired terrorism, and in debates about the merits of faith-based schools; in the subject matter of best-selling books and films; and in the popularity of new age beliefs and practices. The significance of religion in people's lives can also be seen in the most recent Census survey of the British population in 2001 which demonstrated that over 70% of the population identified themselves as Christian (Office for National Statistics, 2004). Thus, although the public practice of a faith may show signs of a decline, it can be argued that public interest in religion and spirituality still remains high.

Indeed, recent national surveys and empirical research suggests that religion is particularly important in the lives of many British older adults and that older adults are the most religiously active members of society (Coleman, Ivani-Chalian, & Robinson, 2004; Davie & Vincent, 1998). However, research on religion and spirituality has been largely ignored in both psychology and gerontology, leaving a deficit in primarily British and European academic understandings of how religious and spiritual beliefs and practices influence the lives of people. In contrast to Britain is America a far more religious society where a high proportion of the population regularly attend church and profess a belief in God and an afterlife. American research has been at the vanguard of investigation into religion and spirituality and has consistently demonstrated its benefits on health and well-being, particularly in older adults.

As such, the first half of the present review will discuss how religion and spirituality have been conceptualised, followed by a review of the health and ageing research that has examined the influence of religion and spirituality. This research will provide the theoretical background to appreciate how religion and spirituality have been studied specifically in the

context of coping and adjustment to bereavement, which will make up the second half of the review.

2.2 Definitions of Religion and Spirituality

Within the psychology of religion literature it has been said that there are as many definitions of religion and spirituality as there are researchers interested in them. Although this is perhaps a slight exaggeration it reflects the fact that there is no scholarly consensus about definitions of religion and spirituality. Indeed, many of the definitions used in past research have been guided as much by researchers' own opinions as they have been by consensus or theory.

General trends in the psychology of religion literature have tended to describe religion narrowly and as being characterised by: the practice of a traditional belief; formal institutions; theological doctrines; dogmatic rituals; hierarchies of clergy; congregations of worshippers; belief in a God; and by identifiable groups. By contrast, spirituality has tended to be described by a much broader and diverse range of characteristics including: feelings of connectedness with God, nature, or humanity; a search for existential meaning and purpose; a sense of awe, transcendence, coherence, or immanence; belief in a higher power, mystical energy, or transcendent reality; and by personal choice. Commenting on the state of modern conceptualisations, Hill et al. (2000) have warned that current research is beginning to polarize spirituality and religion as opposites that represent 'individual versus institution', and 'good versus bad', which is hindering the advancement of agreed upon definitions. Furthermore, Zinnbauer and Pargament (2005) have noted that contemporary descriptions of spirituality are gradually accounting for the experiences that religion once represented.

One of the most influential theorists with regard to discussing the concepts of religion and spirituality who deserves mention is Kenneth Pargament, a leading figure in the psychology of religion. Pargament (1997) defines religion as "a search for significance in ways related to the sacred" (p.32) and defines spirituality as "the search for the sacred" (p.39). From this perspective, religion and spirituality are viewed not as static concepts, but as active and dynamic processes that not only address issues of significant goals and values in people's lives, but provide strategies or pathways for reaching these end points of significance. Within this understanding, religion is seen as much more than just the practice of a belief system, but as a resource of beliefs, practices, and rituals that people can engage in for a wide range of different reasons, both spiritual and secular, for example for health, friendship, education, well-being,

and meaning. Indeed, this approach underlies much of the theorising regarding religious coping, which can succinctly be defined as the use of one's religious belief and practice in coping with stressful or negative life experiences. For Pargament (1997) spirituality is concerned specifically with the sacred, and the beliefs and practices used in one's relationship or connection with the sacred, and is central to religion.

Here an important term that reoccurs throughout the psychology of religion literature is *the sacred*, a term that Pargament (1997, 1999a) suggests refers to concepts such as God, a transcendent or higher power, and the holy or divine, and extends to include objects or elements that have become sanctified through their association with the holy or divine. Indeed, within Pargament's (1997) theorising it is the concept of the sacred that becomes important for understanding religion and spirituality and influences how these concepts are perceived as being related to each another. For example, according to Pargament (1999b) it is the concept of the sacred that provides the essential boundary that sets apart and distinguishes religion and spirituality from secular beliefs and activities. Interestingly, Pargament (1999b) also suggests that as increasing aspects of one's life are perceived as being sacred the distinction between religion and spirituality begins to disappear. Similarly when the search for the sacred unfolds within a traditional religious context the distinction between the two may also be difficult to observe (Zinnbauer & Pargament, 2005).

Although Pargament's (1997) theorising on religion and spirituality is thought-provoking and has been influential in research on religious coping, his definitions have proven difficult to operationalise in research. Indeed, from a research perspective, Pargament's (1997) approach to defining religion and spirituality highlights a significant limitation within the psychology of religion, namely that there can be a difference between how researchers and religious/spiritual believers come to define these concepts.

In contrast, recent definitions of religion and spirituality by Harold Koenig and colleagues have been used in a myriad of health and well-being studies, including those with older adults, and thus provide the definitions used throughout the present research. According to these researchers: "Religion is an organised system of beliefs, practices, rituals and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality), and (b) to foster an understanding of one's relation and responsibility to others in living together in a community" (Koenig, McCullough, & Larson, 2001, p.18). The definition for spirituality is that: "Spirituality is the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which

may (or may not) lead to or arise from the development of religious rituals and the formation of community" (Koenig, McCullough, & Larson, 2001, p.18).

Although developed predominantly in the context of American Protestantism, these definitions are used in the present research as both definitions are inclusive enough to capture some of the phenomenological characteristics of each experience, and easily understandable and broad enough to be used with British older adults with a Christian belief and membership. Interestingly, however, with regard to older adults, a small number of theorists and researchers, including gerontologists, in both Britain and American, have recently suggested that many older adults find it difficult to distinguish between religion and spirituality and identify themselves as both religious and spiritual (Coleman & O'Hanlon, 2004; McFadden, 2005; Nelson-Becker, 2003; Zinnbauer and Pargament (2005). Although more research is needed, this theorising suggests that older adults may perceive religion and spirituality as closely related or overlapping constructs.

Based on the psychology of religion literature, a heuristic overview of the conceptual relationship between religion and spirituality can be discerned and is represented in Figure 4. Diagram A of Figure 4 represents the view taken by Koenig, McCullough, and Larson (2001), and is perhaps the majority view in the psychology of religion, that spirituality is the broader construct within which is the narrower construct of religion, which is one such spirituality. Diagram B represents the view of Pargament (1997) and is perhaps the minority view, that religion is the broader construct within which is the narrower construct of spirituality. Finally, diagram C represents how religion and spirituality can be viewed as overlapping constructs that are similar, and that can be referred to interchangeably.

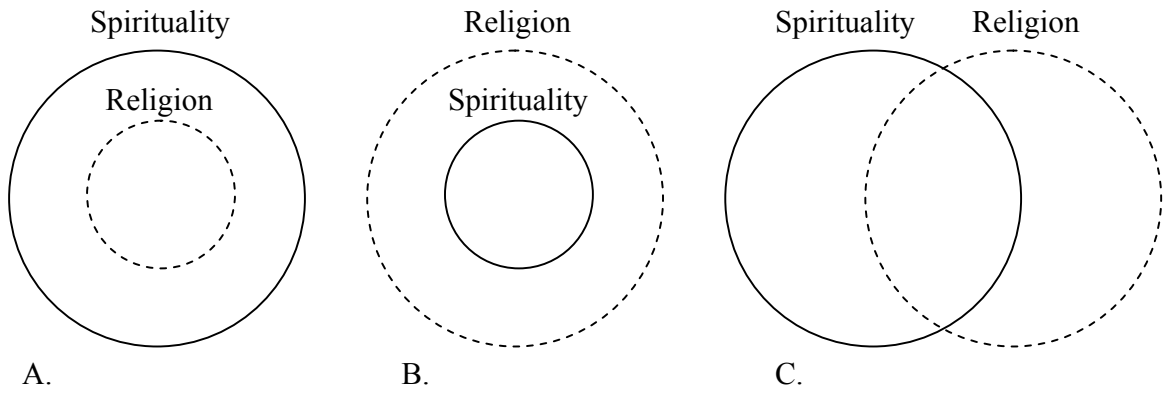


Figure 4. Conceptual model of the relationship between religion and spirituality.

Although researchers may not agree on the definitions and relationships between religion and spirituality, what most researchers do agree upon is that religion and spirituality are not unitary constructs but are multidimensional. This is to say that these constructs are made up of several different aspects or dimensions. Although there is little agreement on the specific number or types of dimensions, amongst the most widely discussed are: religious affiliation/denomination, religious belief, public religious practice (e.g. church attendance), private religious practice (e.g. prayer, reading religious scripture), religious support (from a congregation or ministers), and religious coping. Furthermore, and perhaps most importantly, is that different dimensions may have particular benefits, or complementary benefits, or may vary in importance between individuals.

It is perhaps important to note at this point that in line with general trends in the psychology of religion literature, the present review focuses predominantly on the positive or beneficial aspects of religion and spirituality. However, this is not to say that there are no adverse effects of religion or spirituality. Negative and harmful aspects involving topics such as religious hypocrisy, self-righteousness, prejudice, guilt, self-punishment, narcissism, faith-based terrorism, and congregational conflicts have been discussed elsewhere (see Pargament, 1997).

2.3 Religion, Spirituality, and Physical and Mental Health

By far the largest area of research to examine the influence of religion and spirituality has been in the context of health. In one of the most comprehensive reviews of its kind, Koenig, McCullough, and Larson (2001) compiled all of the studies between the years 1900 and 2000 that had examined the multiple dimensions of religion and their influence on a variety of physical and mental health variables. The review identified that over 1200 studies had been conducted, with many studies using older adults. After critiquing and rating each study for methodological rigour, Koenig et al. (2001) concluded that: "in the vast majority of the cross-sectional studies and prospective cohort studies we identified, religious beliefs and practices rooted within established religious traditions were found to be consistently associated with better health and predicted better health over time" (p.591).

Indeed, amongst the health research focused specifically on older adults there is also evidence to support the positive link between the multiple dimensions of religion and physical and mental health. For example, public and private religious practices have been found to be associated with a lower likelihood of using alcohol (Alexander & Duff, 1991; Krause, 1991)

and of smoking (Koenig et al. 1998a); with improved immune system functioning (Koenig et al. 1997); with better self-rated health (Krause, 1998); with lower likelihood of developing functional impairments (Idler & Kasl, 1997a); and with reduced mortality (Helm, Hays, Flint, Koenig, & Blazer, 2000; Koenig, et al. 1999; Oman & Reed, 1998). Indeed, research by Teinonen, Vahlberg, Isoaho, and Kivelä (2005) using Finnish older adults found that religious attendance was related to a 12-year increase in survival rates. Furthermore, Idler and Kasl (1997b) found that religious service attendance moderated the negative effects of disability on optimism and positive affect, while Kirby, Coleman, and Daley (2004) found that spiritual beliefs moderated the negative effects of frailty on psychological well-being. Religious involvement has also been identified as a strategy used for coping with health problems (Krause, 1991) and in adjustment to age-related challenges (McFadden, 1996).

In the context of mental health, research with older adults has found religious coping to be associated with lower levels of depression (Bosworth, Park, McQuoid, Hays, & Steffens, 2003; Koenig et al. 1995) and religious involvement and commitment to increase speed of recovery from depression (Koenig, George, & Peterson, 1998). Furthermore, importance of religious belief and practice has been found to be associated with increased psychological well-being (Koenig, Kvale, & Ferrel, 1988), increased self-esteem (Krause, 1992), and reduced death anxiety (Wink & Scott, 2005). More recently, spiritual belief and private religious practice have been found to be associated with slower cognitive decline in Alzheimer's disease (Kaufman, Anaki, Binns, & Freedman, 2007).

Reviews by George, Larson, Koenig, and McCullough (2000) and George, Ellison, and Larson (2002) examining the mechanisms underlying the health benefits of religion and spirituality have identified that three main explanatory mechanisms have most often been proposed. The first mechanism explains that religions often promote healthy lifestyle behaviours including respect for the body; abstinence from alcohol, smoking, and illegal drugs; dietary practices; and avoidance of risky sexual and violent behaviours, and it is these healthy lifestyle practices that have a positive influence in preventing ill health. The second mechanism explains that religious members are often incorporated within a wider network of religious social support and that religious members often provide one another with help and support of various kinds in times of need, and may encourage one another in seeking and adhering to medical treatment and in recovery from illness. The final mechanism suggests that religious beliefs can provide a sense of coherence and meaning for its members and provide a worldview that speaks to issues of the nature of human existence, human suffering, and purpose

in life (George et al. 2000, 2002). This sense of coherence and meaning is theorised to influence health by allowing religious believers to find meaning in suffering which in turn can preserve psychological well-being and buffer against the harmful effects of stress on health. Interestingly, however, when these three explanatory mechanisms are compared within the same statistical models, it is the psychological sense of coherence and meaning that appears most significant (George et al. 2000).

More recent reviews have generally agreed with the importance of these mechanisms but highlight the need for future research to identify other less established religious/spiritual mechanisms that may influence health (Oman & Thoresen, 2005). The present body of PhD research, through its in-depth investigation of religious belief and practice, will contribute toward identifying such less established mechanisms that may have implications for future religion and health research.

2.4 Religion, Spirituality, and Ageing

In the context of ageing, at the interface between research on religion/spirituality and gerontology, a field sometimes referred to as religious gerontology, theorising has highlighted the potentially important role that religion and spirituality can play in the lives of older adults, and two broad research themes can be identified. The first research theme focuses on the role of religion and spirituality in successful ageing; while the second theme focuses on change and stability in religion and spirituality with increasing age – or more specifically whether there is an increase in religion or spirituality in later life. Much of the theorising that underlies these research themes centres on the idea that religion and spirituality can be used as a coping resource or can provide strategies for coping with and managing age-related challenges and declines. In addition, this theorising is complemented by theories of ageing (e.g. Carstensen, Isaacowitz, & Charles, 1999; Erikson, 1963; Jung, 1972; Tornstam, 1996) that suggest there is a qualitative shift or developmental change in thinking that accompanies the transition from mid-to-later life, and importantly that some of these shifts or changes overlap with criteria used to define spirituality. For example, criteria such as: an increased search for meaning and purpose in life or a change in the sources of meaning and purpose; increased importance of introspection, contemplation, reflection, life review, reconciliation, and meditation; and increased emphasis on emotion based relationships and motivations.

Recent discussions on successful ageing by Coleman and O'Hanlon (2004) and Sadler and Biggs (2006) highlight that within the gerontological literature there are two broad

understandings of successful ageing – as a state and as a process. The former understanding is based on the theorising of Rowe and Kahn (1998) and views successful ageing as an optimal state of physical, psychological, and social functioning in later life that is characterised by an absence or minimum of disease and disability, by a maintenance or high level of physical and mental abilities, and by a continuing involvement in social activities and life (Coleman & O'Hanlon, 2004; Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002; Sadler & Biggs, 2006). The latter understanding is based on the theory of selective, optimisation with compensation by Baltes and Baltes (1990) and views successful ageing as a process whereby older adults are able to use individualised strategies to adapt and adjust to age related declines, constraints, and losses in order to achieve personally meaningful goals, tasks, and behaviours (Coleman & O'Hanlon, 2004).

Recently, the Rowe and Kahn (1998) model of successful ageing has been advanced by American researchers with an interest in religious gerontology and has influenced how successful ageing is perceived as both a state and a process. Based on the accumulation of health and well-being research showing a positive influence of religious and spiritual variables on the interdependent components of Rowe and Kahn's (1998) conceptual model of successful ageing (i.e. the biological, physical/mental, and social components), Crowther, Parker, Achenbaum, Larimore, and Koenig (2002) have argued that a fourth component should be added to the model that reflects the importance of religion/spirituality in the lives of American older adults. Crowther et al. (2002) have labelled this fourth component *positive spirituality* and suggest that its main aim is to promote health and well-being for self and others in later life.

Crowther et al. (2002) describe positive spirituality as a combination of both the positive characteristics and outcomes of religious and spiritual involvement. Furthermore, that positive spirituality is based on an internalised personal relationship with the sacred or transcendent, involves outward behavioural and inward emotional practices and experiences, and is focused at the level of both the individual and the community.

Positive spirituality is proposed to influence successful ageing by providing strategies that can promote proxies for successful ageing (i.e. health and well-being) via different multi-dimensional pathways or mechanisms. For example, Crowther et al. (2002) suggest that psychologically, positive spirituality can provide a cognitive framework for preserving meaning, purpose, hope, and optimism in the face of illness; that behaviourally it can provide activities such as prayer and meditation that can encourage a sense of control over illness-

related cognitions and stress; and that socially it can provide older adults with a community to keep them engaged with life and in productive activities.

Thus, essentially, for Crowther et al. (2002), positive spirituality is theorised to complement traditional biomedical models of health and well-being in later life that focus on treatment in response to disease or malaise by encouraging older adults to be more responsible or proactive in maximising their own health and well-being. For Crowther et al. (2002) positive spirituality has the potential for providing individual and group strategies for encouraging healthy lifestyle behaviours, for the early detection and prevention of disease, and for adherence to medical treatment and consultations with physicians.

Although the role of religion and spirituality in successful ageing is still an area awaiting more dedicated research, it is hoped that the present body of PhD research will contribute toward this area. The present research should go some way toward tapping into the religious and spiritual strategies used in coping and adjusting to one major issue in later life that can adversely affect mental, physical, emotional, and existential well-being, namely spousal bereavement.

With regard to change and stability in religion or spirituality in later life, early research lent support for the idea that religion did indeed increase with older age (Koenig, Smiley, & Gonzales, 1988). This idea was based on several American large scale national surveys and a broad body of mainly American cross-sectional studies that demonstrated that older adults tended to show higher levels of religious belief and practice, and greater use of religious coping compared with younger adults (Koenig et al. 1988). In addition, many studies of older adults have revealed a positive association between higher levels of religious belief and practice and increased well-being (Koenig, McCullough, & Larson, 2001). The findings of an apparent increase in religion in older age have been explained by the fact that for many older adults, older age brings increased experiences of physical health problems, increased bereavements related to friends and family, and a closer perceived proximity of death, with older adults turning to or increasing the importance of religion as a way of coping. Indeed, McFadden (1996) captures some of the essence of this theorising when she states the following: "For many older persons, religion provides meaning that transcends suffering, loss, and the sure knowledge that death looms somewhere on the horizon" (p.163).

More recent reviews that have included qualitative and longitudinal studies have demonstrated mixed findings and suggest a much more complex picture (Dalby, 2006; McFadden, 1996; Seifert, 2002). A good example of this complexity is captured in a rather

unique longitudinal study by Wink and Dillon (2002). These researchers examined the influence of age, age cohort, and gender on spiritual development across the adult lifespan (from early 30s to late 70s) in two different age cohorts, a younger cohort (born late 1920s) and an older cohort (born early 1920s). Wink and Dillon (2002) found that for men and women in both age cohorts spirituality increased from late middle age to older age, with women being more spiritual in older age compared with men. Furthermore, the younger cohort increased in spirituality throughout their lifespan while the older cohort only showed an increase in spirituality from late middle age to older age. Wink and Dillon (2002) also examined antecedent predictors of spirituality in later life and found that for both men and women religious involvement in early adulthood predicted spirituality in older age. Further analysis by gender revealed that for men spirituality in early adulthood predicted spirituality in older age, while for women negative life events in early and middle adulthood and cognitive characteristics such as introspection and insight predicted spirituality in later life.

In addition, other research provides equally as insightful findings about the complexity of stability and change in religious belief and practice in later life. For example, in a 20 year longitudinal study of 342 British older adults (aged 65 years and over) followed from the late 1970s to 2002, Coleman, Ivani-Chalian, and Robinson (2004) found that for the majority of participants there was stability in the meaningfulness of their Christian belief and practice. However, for approximately a quarter of the sample there was a significant decline in the meaningfulness of their faith. Interviews with participants revealed that the experience of negative life events such as spousal bereavement was a major factor in the decline of their belief and practice. Other findings that Coleman et al. (2004) identified included that it was rare for older adults with no earlier religious commitment to express later that religion had become increasingly meaningful in their lives. Furthermore, analysis by gender revealed that although women were more religious than men there was some evidence for a gender cross-over, with men showing greater potential to become more religious in very late life while women expressed more dissatisfaction. There was also tentative evidence to suggest that a decrease in communal worship with advanced old age may be compensated for by an increase in private religious practice. Indeed, a series of American cross-sectional studies provide support for this idea. Research by Ainlay and colleagues (Ainlay & Hunter, 1984; Ainlay, Singleton, & Swigert, 1992; Ainlay & Smith, 1984) has found that as public religious practice decreased with age due to health and transportation problems, private religious practice remained stable or increased.

Thus, from more recent reviews and empirical research on stability and change in religion and spirituality in later life, it can be discerned that in contrast to chronological age per se being the most important factor eliciting change, at least three other salient factors may be influential. The first factor is religious or spiritual involvement at an earlier age (perhaps childhood or adolescence). As the theorising of Coleman, Ivani-Chalian, and Robinson (2004) highlights, the religious beliefs and practices of significant attachment figures such as parents and grandparents may instil a religious background or identity that older adults maintain or can return to in later life.

The second factor is the socio-historic or cultural period in which the older individual was socialised within (McFadden, 2005; Seifert, 2002). For example, as McFadden (2005) explains, significant periods of the 20th Century that impacted on religious belief and practice such as the Second World War, the Second Vatican Council (1962-1965), and the cultural changes of the 1960s may all create cohorts of older adults with varying understandings and attitudes toward their belief and practice. Indeed, Wink and Dillon (2002) concluded that the linear increase in the spiritual development of their younger cohort with age may have resulted from the fact that the younger cohort was in their 30s during the cultural changes in America in the 1960s and therefore more able to integrate spiritual ideas or interests into their developing adult identity.

The final factor is the influence of negative life experiences and particularly of significant bereavement in later life. Theorising and research suggests that for some older adults significant bereavement such as the loss of a spouse may act as a catalyst for increased belief which may be experienced as a useful and beneficial coping resource, while for others may cause a turning away from faith or feelings of being let down by religion (Coleman, Ivani-Chalian, & Robinson, 2004; Dalby, 2006; Seifert, 2002).

The remainder of the chapter now turns to examining in more detail the theory and research that has examined the positive role that religious and spiritual belief and practice can play for older adults coping and adjusting to spousal bereavement.

2.5 Religion, Spirituality, and Bereavement

In contrast to the relative wealth of research that has examined the influence of religion and spirituality on physical and mental health, far less research has examined the influence of religion and spirituality in coping and adjustment to bereavement. Although early empirical research (e.g. Bornstein et al. 1973; Gass, 1989) and theory (e.g. Wuthnow, Christiano, &

Kuzlowski, 1980) suggested religion was a potentially useful resource in coping with bereavement, disappointingly this early research was never adequately followed up. It is perhaps somewhat timely then that three recent literature reviews have been published that offer an overview of the state of the research and theory in this area. The three reviews include an overall systematic literature review by Becker et al. (2007), and two separate systematic literature searches by Wortmann and Park (2008, 2009), the 2008 review examining the quantitative research and the 2009 review examining the qualitative.

In the systematic literature review by Becker et al. (2007), these researchers highlighted that as few as 32 studies met their strict theoretical, methodological, and statistical criteria for inclusion (see Becker et al. 2007 for details). The review, based on literature published between 1990 and 2005, involving 5715 participants aged between 14 and 93 years, and ranging in time since bereavement from 1 month to 41 years, found that in 94% of the studies, religious or spiritual beliefs had a positive influence on bereavement outcome.

The review by Becker et al. (2007) also highlighted a number of other interesting statistics about the research in this area. For instance, that of the 32 published studies only five focused explicitly on older adults, only four were qualitative studies, and only six studies were from outside of North America with only two being conducted in Britain. Further statistics worth mentioning included that only 32% of participants used in studies had lost a spouse, thus highlighting how little research has examined the use of religion by those who have lost a partner. Furthermore, of the 32 studies, 83% of participants used were protestant, and 69% of participants used were female. These two latter statistics may reflect the over-representation of protestant participants used in American research, while the greater number of females may reflect higher mortality rates for males compared to females, or possibly an increased willingness by females to participate in this kind of research (Stroebe, Stroebe, & Schut, 2003).

In the literature review of the quantitative research by Wortmann and Park (2008), that seemingly did not impose a restriction on year of publication, these researchers identified 73 empirical studies and concluded that overall the findings suggested a generally positive influence of religion on bereavement adjustment. Furthermore, of these 73 studies, only approximately 15 studies had focused on older adults, while only 13 studies had been conducted outside of America (Wortmann & Park, 2008). In the review of the qualitative research, Wortmann and Park (2009) again using no restriction on year of publication, reported 39 studies that met their inclusion criteria, with approximately only 4 studies focused on older adults.

Closer examination of the studies included in these reviews reveal further insights about the research in this area. For example, it can be discerned that many of the studies in this area have used samples with heterogeneous characteristics, such as wide age ranges that include younger, middle-aged, and older adults; variations in the deceased individual and relationship to the deceased; and variations in post-loss time since bereavement. Thus, the present body of research makes it difficult to easily understand how older adults use religious and spiritual resources to cope and adjust specifically to spousal bereavement.

2.6 Theoretical Explanations

Theory explaining the overall salutary effects of religious and spiritual belief and practice on bereavement adjustment and coping is still at an early stage of development, with little clear structure or scholarly consensus. Much of the theorising has been viewed or presented from the perspective of religion/spirituality and has tended to converge on the fact that religion is a multidimensional construct (see above) capable of exerting an influence along several different dimensions (Wortmann & Park, 2008). In contrast, the less emphasised, complementary approach, has been to view the influence of religion/spirituality from the perspective of the individual, or more specifically, how religion/spirituality is experienced at the multidimensional level of the bereaved person. Based on this latter approach, the most obvious experiential levels of religion and spirituality that can be discerned are those of cognition, emotion, behaviour, and social interactions (Carr, 2004; Pargament, 1997; Spilka, 2005).

2.6.1 Religion, Spirituality at the Level of Cognition

At the level of cognition, where arguably most of the theorising has been focused, theorists have explored the relevance of specific and general beliefs, meaning and meaning-making, and positive reappraisals and reinterpretations. At the level of cognition, religious belief in various ways has been described as a framework or cognitive schema that amongst other things provides a general disposition for understanding the world, oneself, and interactions between the two, including understanding of death, bereavement, loss, and suffering (Koenig, McCullough, & Larson, 2001; McIntosh, Silver, & Wortman, 1993; Pargament, 1997; Park, 2005; Spilka, Hood, Hunberger, & Gorsuch, 2003). Within this framework or cognitive schema are specific beliefs that are perhaps unique to religious or spiritual belief systems and which take on added importance following a significant

bereavement. Amongst the specific beliefs theorised as being important is the emphasis on the existence of a supreme being or God that is omnipresent, omniscient, and benevolent; that events such as bereavement occur in accordance with God's will or for a higher purpose; and that God is in different ways supportive (Carr, 2004; Koenig et al. 2001; Pargament, 1997; Wortmann & Park, 2009). Furthermore, there may be death specific beliefs such as belief in an afterlife that in different ways have been described as providing hope, comfort, or consolation (Benore & Park, 2004; Frantz, Trolley, & Johl, 1996; Smith, Range, & Ulmer, 1992; Wuthnow, Christiano, & Kuzlowski, 1980).

From a coping perspective, religious belief as a framework or cognitive schema becomes particularly important during secondary appraisals of the bereavement whereby meanings or explanations for the loss can be actively created that subsequently influence reinterpretations or a reframing of the bereavement in a less threatening, more comforting way (Koenig et al. 2001; Pargament, 1997).

Indeed, religious belief as a fundamental framework, cognitive schema, or disposition can be seen in cognitive models of meaning-making coping with bereavement that include religious/spiritual variables. For example, in Gillies and Neimeyer's (2006) meaning reconstruction model where religious/spiritual belief is seen as a component of "pre-loss meaning structures" (see section 1.14), and in Park's (2005) meaning-making model of coping where religious belief is a component of a "global meaning structure" (see also Benore & Park, 2004). Generally speaking, within these cognitive models, a major role of religious/spiritual belief as a framework is essentially to provide religious/spiritual content to be used in the creation of meanings or explanations for the bereavement that reduce the discrepancy between our generally benevolent view of the world and the negative or malevolent event that has occurred (Park, 2005). According to these models, discrepancies are described as being reduced through a process of assimilation whereby the framework can incorporate the bereavement or accommodation whereby the content/details/structure of the framework need to be changed or modified to incorporate the bereavement (Park, 2005; Wortmann & Park, 2009). Thus, what becomes important to know is the content of these religious frameworks and how they are applied to bereavement. Indeed, this issue is the focus of Study 2, see Chapter 4.

Empirical support for the relationship between religious/spiritual beliefs and bereavement adjustment comes from studies using a range of participant groups and study designs. For example, in a cross-sectional study of older adults (aged 65 to 87 years) who had experienced spousal bereavement within the previous 24 months, Fry (2001) found that

existential variables including importance of religion, and spiritual beliefs and practices were significant predictors of psychological well-being. Furthermore, in a longitudinal study of adults (mean age 53 years) who had lost a spouse/partner, relative, or close friend, Walsh, King, Jones, Tookman, and Blizard (2002) found that those with a strong spiritual belief resolved their grief quicker over the first 14 months post-bereavement compared to those with a low or no spiritual belief. In addition, in a prospective study of Japanese older adults (mean age 69.1 years), Krause et al. (2002) found that those who experienced bereavement from a family member or close friend and who had a belief in a positive afterlife were associated with a lower likelihood of reporting future hypertension.

Empirical support for the meaning-making and positive reappraisal theorising comes from Park (2005) who found that in bereaved college students (mean age 19.2 years) that positive reappraisal meaning-making mediated the relationship between intrinsic religiousness and better bereavement adjustment. In a further study of older adults (mean age 77.9 years), Park (2006) found some support that reappraised meaning-making mediated the association between religious belief, religious practice, and religious coping, and adjustment to what participants reported as their most traumatic and stressful life experience, the majority of which was bereavement related to a spouse or child. We return to the subjects of religion, bereavement, and meaning-making in Chapter 4, Study 2.

2.6.2 Religion, Spirituality at the Level of Emotion

At the level of emotion, in contrast to the level of cognition, there is very little research or theorising on the role of emotion elicited by religion or spirituality in coping and adjusting to bereavement. This situation may partly be accounted for by a lack of available scales to measure religious or spiritual emotion. However, religious emotion or feeling is considered central to religious experience (Emmons, 2005; Pargament, 1997). Both Emmons (2005) and Pargament (1997) highlight how early theorists who examined religion noted that the essence of religious experience tended to reside in emotion not intellect or belief, and that religious emotions were often viewed as indicators of genuine religious or spiritual experience. Even today within many world religions and religious denominations there can be found different attitudes and practices towards encouraging certain emotional experiences or states, from the encouragement of intense positive emotions; to emotional calmness, stillness, or mindfulness; to asceticism and an avoidance or minimisation of emotion and sensation (Emmons, 2005). Indeed, based on the theorising of Emmons (2005) and others, a myriad of positive and

negative emotions and emotional experiences associated with religion and spirituality can be identified, for example: awe, reverence, wonder, happiness, joy, security, gratitude, love, compassion, hope, empathy, sorrow, sadness, guilt (Emmons, 2005); a sense of closeness to God or others, a sense of reassurance (Spilka, Hood, Hunberger, & Gorsuch, 2003); and feelings of inner peace and harmony (Idler et al. 2003).

Although there is debate over the uniqueness of these religious emotions and whether they differ from emotions that are non-religious (Emmons, 2005), the observation of a link between religion and the generation of emotions has led some theorists to see religion as a potential vehicle for emotion regulation (Emmons, 2005) or emotional self-maintenance (Grzymala-Moszczyńska & Simpson, 1997), and emotional catharsis (McFadden & Levin, 1996).

In the context of bereavement, based on the broader theorising on religious emotion it can be discerned that religion may be influential at the level of emotion in three main ways. First, in the generation of positive emotions (Emmons, 2005); second, in the alleviation of negative emotions such as depression and anxiety (Coleman & O'Hanlon, 2004; Fry, 2001); and third, in emotion regulation/self-maintenance and emotional catharsis that can be applied to grief (Jacobs, 1992).

With regard to these three possibilities, only the second has received some support. In the above mentioned study by Fry (2001), she used a composite measure of psychological well-being that included measures of depression and anxiety, and found that existential variables including spiritual beliefs and practices predicted better psychological well-being. With regard to emotion regulation and emotional catharsis as applied to grief, there is little research or theorising detailing the conditions under which these processes might occur. In Chapters 4 and 5 we will return to discussing these processes.

In an alternative line of research, that has relevance at the emotional level of religion and bereavement, is the theorising of Lee Kirkpatrick who has applied attachment theory to understanding religion. In his book long overview of his theorising, Kirkpatrick (2005) has put forward the theoretical argument that religion, in particular Christianity, can serve the function of providing several attachment needs. For example, Kirkpatrick (2005) suggests that God can act as a secure attachment figure that religious individuals can have a perceived personal relationship with, and that through specific beliefs and practices can seek or maintain a sense of close proximity; that God can provide a haven of safety during times of distress, crisis, or threat, and through which comfort and safety can be experienced; and that God can provide a

secure base for religious individuals to confidently explore their world and face any problems or challenges with a sense of courage and trust. Indeed, for Kirkpatrick (2005) the fact that most Christian denominations describe God as in some way being personal, omniscient, omnipresent, and omnipotent makes God a candidate for being an almost ideal attachment figure.

Based on this theory, Kirkpatrick (2005) has suggested an emotional compensation hypothesis to account for the observation that following a traumatic or distressing event such as a significant bereavement, people often describe an increase in either the importance of their religious belief, their religious practice, or the role of God in one's life. According to this hypothesis, bereavement from a significant attachment figure such as a spouse can activate or trigger the attachment system to search for a substitute attachment figure (Kirkpatrick, 2005). When these conditions are experienced, the bereaved individual may perceive God as one such substitute and may increase the importance of their religious belief, religious practice, or their relationship with God in an attempt to emotionally compensate for the lost relationship and felt sense of security with their spouse. Indeed, Kirkpatrick (2005) suggests that this hypothesis may also account for the observation that the importance of religious belief tends to increase in later life, a time when older adults are more likely to experience bereavement episodes and loss of attachment figures (e.g. parents, siblings, spouse). Recent support for this hypothesis comes from Brown, Nesse, House, and Utz (2004) who found that in a prospective study of adults (aged 38 to 92 years), that following spousal bereavement importance of religious/spiritual belief did indeed increase and this increase was related to a reduction in grief.

2.6.3 Religion, Spirituality at the Level of Behaviour

At the level of behaviour, theorising has focused on the role played by religious practices such as church attendance, prayer, and religious rituals in coping and adjustment to bereavement. However, the majority of empirical research to examine religious practice in bereavement has tended to focus on the influence of church attendance. Indeed, in the context of bereavement, church attendance has been found to be associated with a range of adjustment indicators including self-esteem (Sherkat & Reed, 1992); positive affect (McGloshen & O'Bryant, 1988); optimism (Sanders, 1980); and lower depression (Siegel & Kuykendall, 1990).

The theoretical explanations for the beneficial effects of church attendance on bereavement adjustment suggest the importance of two main pathways. The first pathway, and

perhaps the most widely agreed upon, is that regular church attendance can provide access to social support from a religious congregation who may be likely to respond to the bereaved individual with varying levels and types of help and support. Indeed, because the role of religious social support in bereavement can take many different forms this resource is considered in more detail below (see section 2.6.4). The second pathway, is that church attendance can facilitate access to other sources of religious meaning that may in some way be helpful. For example, access to religious teachings and literature may be useful in providing a sense of comfort (Roff, Durkin, Sun & Klemmack, 2007), and access to religious rituals may reinforce commitment to religious beliefs and values (Carr, 2004; Spilka, 2005), as well as encouraging a sense of belonging, solidarity, and closeness among religious members (Carr, 2004, Spilka, Hood, Hunberger, & Gorsuch, 2003; Wuthnow, Christiano, & Kuzlowski, 1980). Access to sources of religious meaning may also help the bereaved in making sense and understanding their loss (Wuthnow et al. 1980).

Some support for the relationship between church attendance, the pathways of social support and finding meaning, and bereavement adjustment comes from the frequently cited study by McIntosh, Silver, and Wortman (1993) of parents (age range 15 to 40 years) coping with the death of a baby to sudden infant death syndrome. Using path analysis statistical techniques, McIntosh et al. (1993) were able to demonstrate that increased perception of social support and finding meaning in the loss mediated the relationship between increased frequency of church attendance and increased well-being and reduced distress at 3 weeks and 18 months post-loss.

With regard to prayer, the psychology of religion literature suggests that there are as many as 100 different types of prayer depending on the intentions and needs of the individual, for example prayers of petition, intercession, adoration, thanksgiving, and self-aggrandizement, to name but a few (Spilka, 2005). Theorised predominantly as a way to communicate with God, prayer is often used as a way to ask God for help or support in times of distress or in dealing with challenges or problems that an individual perceives as having little control over (Spilka, 2005).

Within the religion and health research, prayer has been identified as a resource used in several different coping contexts, for example by older adults recently admitted to hospital (Koenig, 1998); by older adults coping with a current and long term stressor (Koenig, George, & Siegler, 1988); by middle aged and older adults convalescing after cardiac surgery (Ai, Dunkle, Peterson, & Bolling, 1998); and by people coping with depression and chronic pain

(Koenig, McCullough, & Larson, 2001). However, in the context of bereavement, although prayer has been identified as a potential source of comfort (Frantz, Trolley, & Johl, 1996) there has been little detailed theory or research on the role of prayer in bereavement. However, recent research by Roff, Durkin, Sun, and Klemmack (2007) does provide reason to believe that prayer may be an important coping resource in bereavement and offers insight into its use.

In their recent cross-sectional study, Roff, Durkin, Sun, and Klemmack (2007) compared bereaved and married older adults on religious practice, socio-economic status, and well-being (measured using a composite index including items on happiness, excitement with life, satisfaction with financial situation, and hopefulness). Among the different results, Roff et al. (2007) found that bereaved older adults (mean age 75.6 years) scored lower on all the aspects of well-being and socio-economic status compared with married older adults (mean age 69.2 years), but importantly that bereaved older adults scored higher on frequency of private prayer, and that frequency of prayer was inversely related to well-being. Roff et al. accounted for the prayer findings with the explanation that for bereaved older adults because of their lower well-being (and more adverse life conditions) they feel an increased need to communicate with and rely upon God for help and support compared with married older adults. Furthermore, Roff et al. suggested that the increased use of prayer by bereaved older adults may reflect a more state than trait characteristic, a specific coping response elicited by the distress of bereavement.

2.6.4 Religion, Spirituality at the Level of Social Interactions

At the level of social interactions, theorising has focused on the role played by social support provided by a religious congregation, sometimes referred to as religious social support or church-based social support, in coping and adjustment to bereavement. Much of this theorising is based on the observation that religion and religious coping are social phenomena, that is that people do not practice their belief in a social vacuum but in the context of like-minded other people (Krause, Ellison, Shaw, Marcum, & Boardman, 2001). As such religious involvement can give rise to strong interpersonal relationships and social ties, creating relationships that complement family support systems and can compensate for an absence of support from family or friends (Krause et al. 2001; Pargament, 1997; Steinitz, 1981). At the same time the stress and coping literature suggests that when people are faced with a stressful situation they often turn to other people for help (Lazarus & Folkman, 1984; Pargament, 1997). In addition, central to many of the world's religions, and certainly the many denominations of

Christianity, is an emphasis on compassion, kindness, and helping other people - especially those in need of help (Ellison & Levin, 1998; Krause et al. 2001).

The religious social support theorising has also been influenced by research findings involving secular social support from friends and family. Within the ageing and bereavement literature the beneficial effects of this kind of social support on bereavement adjustment, health, and well-being have been frequently identified (Stroebe & Schut, 2001; Stylianos & Vachon, 1993; Wolff & Wortman, 2006). In addition, social support has been theorised as being beneficial throughout the lifespan and particularly so in later life, a time when social support networks tend to diminish (Hansson & Stroebe, 2007).

Influenced by the secular social support literature that conceptualises social support as a multidimensional construct (Ellison & Levin, 1998; Sherbourne & Stewart, 1991), the broader psychology of religion theorising suggests that religious social support can provide several different dimensions or types of support. The most widely discussed support dimensions include: instrumental support (provision of tangible or material help); informational support (provision of information or advice); emotional support (provision of empathic understanding or care); and spiritual support. With regard to this latter support dimension, Krause, Ellison, Shaw, Marcum, and Boardman (2001) define spiritual support as "the tendency for coreligionists to help a person maintain and deepen his or her faith by encouraging the person to integrate religious beliefs and practices into daily life" (p.642), as well as the tendency for religious members to share their religious experiences (Krause et al. 2001). Thus, the religious social support theorising suggests that religious members can provide support that is both secular in nature and also uniquely religious (Krause et al. 2001).

Importantly, however, the religious social support literature suggests that certain criteria might need to be met first in order to receive support. For example, a religious member may need to be a frequent attendee at religious services in order to be sufficiently well integrated enough within a social network of potential support, and in order to make potential support givers aware of one's situation and needs (Krause, 2002). Furthermore, a religious individual may need to perceive the religious group as sufficiently cohesive enough as to provide support (Krause, 2002). Moreover, adherence to and the perceived value of the support offered may vary depending on the characteristics of the source of the support, for example whether from a member of the clergy or a fellow parishioner (Krause, Ellison, Shaw, Marcum, & Boardman, 2001; Krause, 2002).

In the context of bereavement, several authorities in the fields of health, ageing, and religion (e.g. Ellison & Levin, 1998; Idler et al. 2003) have suggested that religious social support may be able to provide comfort and offset the negative effects of bereavement. Recently, Carr (2004) has applied the spiritual support theorising of Krause et al. (2001; Krause, 2002) directly to explaining how religious social support may help religious older adults who have experienced spousal bereavement cope with their loss. From Carr's (2004) theorising two important ways can be discerned. The first way is that recently bereaved religious older adults may be able to gain some perspective on their loss from listening to the shared experiences and stories of bereavement and religion from other religious older adults. The second way is that recently bereaved religious older adults may receive help or guidance from more experienced bereaved older adults about how to apply their religious belief and practice in coping and adjusting to their loss. In addition, fellow religious older adults who have experienced similar spousal bereavement may be able to provide a shared sense of understanding in their loss from which meaning may be found (McIntosh, Silver, & Wortman, 1993).

Although in the broader psychology of religion, religious social support has been suggested as helpful in coping with negative life events, the recent review by Wortmann and Park (2008) revealed that as few as three studies had examined religious social support in the context of coping with bereavement, and only two of these studies found positive effects. Indeed, it is only recently that a valid and reliable scale to measure religious social support has even become available (see Idler et al. 2003). With regard to the empirical support, in the earlier mentioned study by Fry (2001) of older adults who had lost a spouse in the pervious 24 months, high levels of accessibility to religious social support was related to increased psychological well-being. In addition, in an earlier study by Bahr and Harvey (1980) of widows (median age 37 years) who had lost a husband 6 months earlier in a mining fire, Bahr and Harvey (1980) found that religious social support was related to higher levels of quality of life. It is also perhaps worth noting that in a study by Krause (2002) of church-based social support and health in older adults (average age 74.4 years), that Krause (2002) found religious social support to be related to both increased optimism and better self-rated health. Two factors that may be relevant in bereavement adjustment (Nolen-Hoeksema & Larson, 1999; Pienta & Franks, 2006).

Thus, although the empirical research is limited, the religious social support theorising suggests that for bereaved older adults who are well integrated within a cohesive religious

congregation not only is there the potential to receive help or support but also the potential to learn how to use their belief and practice as a coping resource, and these processes may facilitate adjustment.

2.7 Summary

In summary, three recent (e.g. Becker et al. 2007; Wortmann & Park, 2008, 2009), and indeed two older reviews (e.g. Koenig, McCullough, & Larson, 2001; Michael, Crowther, Schmid, & Allen, 2003), suggest that religion and spirituality have a generally positive influence on those coping and adjusting to bereavement. However, the reviews highlight several omissions in the current theoretical and empirical knowledge base that the present body of research hopes to contribute toward.

At present, very little research has examined how British older adults cope and adjust specifically to spousal bereavement, and even less has examined how British older adults use religious and spiritual resources in this coping and adjustment context. Furthermore, there is very little research of a qualitative nature detailing the specific religious and spiritual beliefs and practices underlying some of the quantitative findings.

In addition, there is still very little detailed theory or unifying theory explaining how the different dimensions of religion and spirituality exert a positive influence on bereavement coping and adjustment. There also seems to be little if any research that has attempted to link or incorporate findings on religious and spiritual coping within existing theories of coping with bereavement. Indeed, one arguable interpretation of the present reviews is that bereavement theorists have addressed the issue of religion and spirituality as a potential coping resource far less than psychology of religion theorists who have applied their understanding of religion and spirituality to the context of bereavement.

Thus, the purpose of the present thesis is to advance theory explaining how religious and spiritual belief and practice positively influence coping and adjustment to spousal bereavement in British older adults. In addition, the present research will also examine whether religious and spiritual findings are compatible with the predictions of bereavement theories.

Finally, a number of researchers (e.g. Coleman, McKiernan, Mills, & Speck, 2007; Pargament, 1997) have highlighted that religion and spirituality are most revealingly understood when examined within a specific context. Thus, the present body of research will contribute toward addressing the recent call by Pargament (2002) and others for more dedicated

research examining how helpful different expressions of religious belief and practice are for a particular group of people in a specific context.

PART 2

Chapter 3

Personal Beliefs and Longer Term Coping and Adjustment to Spousal Bereavement in Later Life: A Follow-Up Investigation

3.1 Introduction

The term *personal beliefs* refers to the different systems of belief that people use to search for personal meaning in life, in death, and related to other existential issues. Three broad types of personal belief are termed religious, spiritual, and philosophical. This latter type refers to a belief that has no reference to a God or other transcendent or influential power. Recent research and theorising has highlighted that the use of different personal beliefs by older adults coping and adjusting to spousal bereavement has been largely ignored in British psychology and social gerontology (Coleman, 2010; Coleman, McKiernan, Mills, & Speck, 2002, 2007; Coleman & O'Hanlon, 2004). In addition, there has been very little research that has followed-up how British older adults cope and adjust to spousal bereavement in the longer term during the post-bereavement years. This situation has left omissions in our understanding about the coping processes and resources used by bereaved older adults in longer term coping and adjustment, and where older adults' personal beliefs sit amongst other potential resources.

Influenced by these issues, the first study of this PhD thesis aimed to follow-up survivors of a previous longitudinal study of spousal bereavement and personal beliefs by Coleman, McKiernan, Mills, and Speck, (2002, 2007) and to investigate how participants had coped and adjusted since last interviewed in 2001. This longitudinal follow-up study was considered an ideal first study because it would allow for older adults who hold varying personal beliefs and who had experienced spousal bereavement to be interviewed. Areas that could then be explored would include what content contribute to different personal belief dispositions, how personal beliefs may give meaning and purpose to life, and how personal beliefs are used to cope with spousal bereavement, are important in daily living, and are maintained in the context of an increasingly secular society.

In their original study, Coleman, McKiernan, Mills, and Speck (2002, 2007) followed 26 recently bereaved older adults, mean age 74 years, with varying personal beliefs, over a one year period, and interviewed participants about their coping and adjustment on three occasions throughout the second year of their bereavement. The first interview was conducted in 2000 shortly after the first anniversary of the death of each participant's spouse, the second interview was six months later, and the final interview was shortly after the second year anniversary of the death. In addition, during interviews Coleman et al. (2002, 2007) administered scales to

measure strength of religious/spiritual belief, personal meaning in life, depression, and grief. During analysis, Coleman et al. were able to use participants' scores on strength of religious/spiritual belief to categorise participants as having a Christian belief that was either strong, moderate, or no/weak. This latter group with no religious or spiritual belief was characterised as having a secular philosophy of life.

The results of this study revealed that high depression and grief scores were concentrated around those with a moderate and no/weak belief, and that high scores on depression and grief were associated with low personal meaning in life. In contrast, was that those with a strong religious belief and a strong atheist belief who had low depression and grief scores, and high personal meaning in life. Further case study analysis revealed that those with a strong religious or atheist belief were aided in coping by being able to draw comfort and support from their certainty in their respective beliefs, while those specifically with a moderate belief who were characterised by religious doubts and uncertainty were unable to find much consolation or comfort in their belief.

The study by Coleman, McKiernan, Mills, and Speck (2002, 2007) had addressed an earlier call for more research to be conducted on religion and spirituality in British gerontology, and had identified that there could be differences in coping amongst British older adults based on strength of personal belief. A strong Christian and atheist belief had seemed to facilitate coping during the second year of bereavement by perhaps buffering against some of the negative effects of depression and grief, and by preserving personal meaning in life.

Other British research has also suggested that personal beliefs can be influential in coping with a significant bereavement. In a prospective study by Walsh, King, Jones, Tookman, and Blizard (2002), these researchers followed a sample of adults, mean age 53 years, over the first 14 months after experiencing the death of a close relative. Participants were categorised as having either a strong, low, or no spiritual belief and followed-up at the 1, 9, and 14 month time points. Results revealed that those with a strong spiritual belief had lower grief at each time point compared with those with no spiritual belief, and lower grief at 1 and 9 months compared with those with a low spiritual belief. Furthermore, those with a strong spiritual belief showed a gradual decline in their grief at each time point, while those with no spiritual belief showed little change from 1 to 9 months and an increase in grief at 14 months. Those with a low spiritual belief showed a similar pattern with little change in grief from 1 to 9 months but a large decline in grief from 9 to 14 months. Walsh et al. (2002) concluded that strength of spiritual belief was a predictor of faster and more complete resolution of grief.

Support for the importance of religious belief and practice following bereavement comes from a qualitative interview study reported by Speck et al. (2005) of British older adults, mean age 74 years, who had experienced spousal bereavement between 3 months and 60 years ago. As explained by Speck et al. (2005) although the study's original focus was on the influence of gender and bereavement on well-being, during interviews many participants spontaneously mentioned the importance of their religious belief and church attendance following bereavement. Furthermore, for the majority of those with a religious faith their belief and attendance had remained stable following bereavement, while only a very small percent expressed any decline in religious belief or practice. More recently, research by Wilkinson and Coleman (2010) using qualitative case study comparisons of older adults has suggested that a strong atheist belief can be as helpful in coping with a significant bereavement as a strong religious belief. These researchers concluded that although the content of these personal beliefs may differ, these systems of belief may function in similar ways.

The present study will be able to identify if the benefits of a strong belief extend beyond the first two years of experiencing bereavement. In addition, the present study will also be able to identify whether different personal beliefs are experienced as useful in longer term coping and adjustment, whether different personal beliefs are associated with differences in coping strategies and resources used, and whether there are any differences in longer term coping based on differences in personal beliefs.

3.1.1 The Present Study

The objective of the present study was to follow-up and interview again as many of the participants from the original study by Coleman, McKiernan, Mills, and Speck (2002, 2007) as possible. The aim would be to explore in more detail the religious and secular personal beliefs of this sample of British older adults and to investigate the coping processes used by this sample in longer term coping and adjustment to spousal bereavement. Participants would be interviewed about their experiences of coping and adjustment in the intervening years since they were last interviewed, about the importance of any strongly held personal beliefs, and about the role of personal beliefs in longer term coping and adjustment. The study would also re-administer the scales used by Coleman et al. (2002, 2007) measuring strength of religious/spiritual belief, personal meaning in life, depression, and grief, and examine any variations in these variables over time. Thematic analysis would be applied to participant interview transcripts in order to identify coping themes, that is both secular and religious

coping strategies, techniques, and resources used, for the sample as a whole and consistent with the original study when participants were combined into strength of religious belief sub-groups (i.e. strong, moderate, and no/weak belief). Finally, the present study would further contribute toward identifying whether the findings from the mainly American research showing a beneficial influence of religion on bereavement (Wortmann & Park, 2008, 2009) generalise to a British sample of older adults.

3.2 Method

3.2.1 Participants and Recruitment

There were 12 participants used in the study. All of the participants were survivors of a previous longitudinal study of personal beliefs and spousal bereavement by Coleman, McKiernan, Mills, and Speck (2002, 2007). The mean age of participants was 75.8 years, (SD) = 9.5 years, with an age range of 54 to 90 years. There were ten females and two males, and all participants were Caucasian.

All of the 26 older adults who participated in the original study by Coleman et al. (2002, 2007) were sent a cover letter asking if they would be willing to participate in the follow-up study and an information sheet explaining the rationale for the study. Participants indicated their interest in participating by posting back in a researcher addressed freepost envelope a participation reply form detailing their name, address, post code, telephone number, email if applicable, and a convenient time for the principal researcher to telephone the participant to arrange the interview.

Of the 26 participants approached, 45% (12) agreed to be interviewed; 12% (3) declined to participate due to health problems (one participant had become completely visually impaired, and two participants stated feeling too frail); 12% (3) were confirmed deceased by relatives; 8% (2) were confirmed moved away and were no longer contactable; and 23% (6) were out of contact by both letter and telephone (it is possible that some of the participants in this latter group may have either moved to a new location or had passed away).

All of the participants had been bereaved for approximately 7.5 to 8 years. The sample had experienced both bereavement preceded by a chronic illness 9 (75%) and sudden bereavement 3 (25%). Causes of bereavement included: 7 (59%) heart or lung conditions; 2 (17%) cerebral disease or complication; 1 (8%) cancer; 1 (8%) specific organ failure; and 1 (8%) dementia.

It was approximately 5.5 years since participants were last interviewed. Eleven of the interviews were conducted between December 2006 and February 2007, one participant was interviewed in June, 2007. This latter participant could not be interviewed earlier due to convalescing from eye surgery but wanted to participate at a later date.

3.2.1.1 Sample Personal Belief Characteristics

As detailed by Coleman et al. (2002, 2007), all of the participants had experienced a strong Christian upbringing, education, or socialisation involving one or more of the following:

one or both parents being a Christian, regular attendance at a local Church Sunday school, and daily attendance at a religious school.

Of the eight (66.6%) participants who stated having a religious belief, seven reported their denomination as Church of England, while one reported themselves as Salvationist (Salvation Army). Four (33.3%) participants stated having no religious or spiritual belief. Of particular note is that participants in this latter group who stated having no religious belief during interviews, had during the course of their lives decided to reject their Christian belief.

3.2.1.2 Living Circumstances

None of the participants had remarried following their bereavement or indicated being in a new personal (romantic) relationship. Eleven of the participants were living alone in their own home, while one participant was living independently in sheltered housing. Eleven of the participants had retired, while one participant, the youngest of the sample, was still working full time. Overall, participants were drawn from across two counties in the south of England and lived in both urban and rural areas in and on the outskirts of two large cities.

3.2.2 Design

The design used was similar to that employed by Coleman et al. (2002, 2007). The study used a mixed methods design that involved semi-structured interviews and four questionnaire instruments measuring depression, personal meaning, grief, and strength of religious/spiritual belief. Semi-structured interviews allowed participants to express at length and in detail their subjective thoughts, feelings, and experiences related to their personal beliefs, and coping and adjustment to the loss of their spouse since last interviewed. Interviews were analysed using thematic analysis across the sample as a whole and when participants were combined into strength of personal belief sub-group (i.e. strong belief, moderate belief, no/weak belief).

3.2.3 Materials and Apparatus

An informed consent form (see Appendix A) and debriefing form (see Appendix B) were provided to all participants. Of particular note is that the debriefing form contained the contact details of a trained counsellor experienced in dealing with bereavement and the researcher who interviewed participants in the original study. This information was included in

case any of the participants wanted to contact a counsellor about any aspect of their bereavement.

The standardised questionnaire instruments used in the follow-up study are the same measures that were used in the original study by Coleman et al. (2002, 2007).

3.2.3.1 Depression

The Geriatric Depression Scale (GDS; Sheikh & Yesavage, 1986; see Appendix C) was used to measure depression. The GDS has been specifically developed and designed in the context of older age groups and with sensitivity given to the circumstances of depression relevant to older adults. One of the unique features of the GDS is that unlike many other depression scales, the GDS does not contain items measuring somatic symptoms that, although related to the normal ageing process and not depression, could artificially inflate or confound depression scores in older age groups. The GDS contains 15 items and is measured using a dichotomous "yes/no" response format. Scores range between 0 and 15 with higher scores indicating increased likelihood of depression. Sheikh and Yesavage (1986) have suggested that the GDS is a promising screening tool for detecting depression and have reported that a score ranging between 0 and 4 be considered within normal parameters while a score of 5 or above be considered a cut-off for possible depression.

Since the development of the GDS the validity of the scale has been supported by a number of studies across various settings including: the local community (Ingram, 1996), geriatric units (Herrmann et al. 1996), and in general practice (Arthur, Jagger, Lindesay, Graham, & Clarke, 1999). Furthermore, several studies have also reported high internal consistency reliabilities (Almeida & Almeida, 1999; van Marwijk et al. 1995), while in a sample of British older adults, D'ath, Katona, Mullan, Evans, and Katona (1994) have reported an internal consistency reliability of 0.80. According to a review of the GDS by Montorio and Izal (1996) the GDS is a well suited self-report measure for detecting depression in community dwelling older adults.

3.2.3.2 Personal Meaning

The Personal Meaning Index (PMI; Reker, 1992; see Appendix D) was used to measure personal meaning. Reker (1992) defined personal meaning as "having life goals, having a mission in life, having a sense of direction from past, present, and future, and having a logically integrated and consistent understanding of self, others, and life in general" (p.20). The PMI is a

composite measure derived from the Purpose and Coherence subsections of the Life Attitude Profile-Revised (LAP-R) a multidimensional questionnaire developed for use with older adults and designed as an attempt to operationalise and measure the meaning concepts theorised by Viktor Frankl.

The PMI consists of 16 items measured along a seven point Likert response format ranging from 1 (strongly disagree) to 7 (strongly agree). Scores range between 16 and 112, with higher scores reflecting a stronger sense of personal meaning in one's life. Reker (1992) has reported that the PMI has a satisfactory underlying factor structure, good construct validity, test-retest reliability of 0.90 over a four to six week period, and internal consistency reliabilities ranging from 0.89 to 0.91. More recently, Reker and Fry (2003) have reported an internal consistency reliability of 0.97 in a sample of community residing older adults.

3.2.3.3 Grief

The Bereavement Experiences Index (BEI; McKiernan, Carr, Waller, & Spreadbury, 2007; Appendix E) was used to measure level of grief response intensity. The BEI was developed predominantly by clinicians and designed to measure both the cognitive and affective components of grief. The scale consists of 45 statements related to thoughts and emotions commonly experienced during bereavement and participants are asked to indicate how close each statement is with their own experience of bereavement. Items are measured along a six point response format ranging from 1 (completely false) to 6 (completely true). Once certain items have been reversed, scores for each item are summed to give an overall score ranging between 45 and 270, with higher scores indicating increased intensity of grief symptoms related to the bereavement experience.

McKiernan et al. (2007) have demonstrated that the scale has satisfactory preliminary psychometric properties including: good content validity with items developed from interviews with bereaved adults; good construct validity with scores on the BEI correlating with the total score and relevant subsections of the General Health Questionnaire (Goldberg & Hillier, 1979); and good face validity with high acceptability of items in use with recently bereaved adults. Furthermore, McKiernan et al. (2007) have reported that the BEI has good internal consistency reliability with a Cronbach's alpha of 0.80.

3.2.3.4 Religious and Spiritual Belief

The Royal Free Interview for Spiritual and Religious Beliefs (King, Speck, & Thomas, 2001; see Appendix F) was used to measure strength of religious and spiritual belief. This scale is made up of 6 items that assess strength of belief in a religious or spiritual transcendent power or force separate from oneself, and strength of belief about the degree of influence this power or force has in the life of the individual and in the world. The scale uses a visual analogue response format ranging from 0 to 10, and scores for each item are summed to give an overall score between 0 and 60. Higher scores indicate increased strength of belief in a spiritual power or force, and suggest that spiritual belief and practice is important in the life of the individual.

In keeping with the study by Coleman et al. (2002, 2007), the Royal Free Interview for Spiritual and Religious Beliefs was also used to categorise participants as those with a strong belief (who on average score 8 or above on each item), those with a moderate belief (scoring between 3 and 7), and those with a weak or no belief (scoring 2 or less). The scale also contains sections measuring whether the participant has a religious or spiritual understanding of their life; religious denomination; frequency of attendance at religious services; and frequency of engagement in prayer.

The scale is considered to have good criterion validity with total scale score and individual item scores correlating highly with the Intrinsic Religious Motivation Scale (Hoge, 1972), and good internal consistency reliability with Cronbach's alphas of 0.89 in a sample with a religious and spiritual belief, and 0.74 in an older sample from a fundamentalist Christian church. More recently, Kirby, Coleman, and Daley (2004) reported a Cronbach's alpha of 0.85 in a sample of British older adults.

3.2.3.5 Interview Schedule

An interview schedule (see Appendix G) was designed as a flexible overview of questions of interest, and structured based on the practical guides to constructing an interview schedule and conducting semi-structured interviews in Marks and Yardley (2004) and Smith (2003).

Item development for the interview schedule was influenced predominantly by the research and original interview schedules used by Coleman et al. (2002, 2007), but also by the theorising of Carstensen, Isaacowitz, and Charles (1999) and Labouvie-Vief (2005) on managing and regulating emotions in later life, and by the theorising of Tornstam (1996) and

Marcoen (2005) on age and adjustment related existential contemplation and spiritual development.

Questions on the interview schedule were broadly grouped within five main categories: 1) Experiences during the intervening years since last interviewed; 2) personal beliefs and practices; 3) personal beliefs and acceptance, adjustment, and coping with spousal bereavement; 4) management of emotions/grief; and 5) existential contemplation/questioning.

The interview schedule contained nine main questions that attempted to be as open-ended as possible in order to encourage participants to respond at length and in detail with any information they felt relevant. The interview schedule also included prompts that would help the researcher not to forget anything potentially important, for example "what denomination do you consider yourself to belong to?" or "can you tell me if you ever pray?" In addition, during interviews probes were used spontaneously and where appropriate in order to allow participants to supplement and elaborate on their responses and to allow participants to move into new insightful areas (Wilkinson, Joffe, & Yardley, 2004). An example of a probe was "tell me more about that experience" or "how do you feel about that now?"

More specifically, question one asked participants to talk about their life now and during the intervening years since they were lasted interviewed, and to describe any experiences that they had found particularly important or difficult. Question two focused on establishing the religious, spiritual, or philosophy of life personal beliefs of participants, the importance of these personal beliefs, and details about religious practices. Questions three to five focused on the role played by personal beliefs in accepting, coping and adjusting to bereavement during the intervening years. Question six investigated stability and change in personal beliefs during the intervening years since bereavement. Question seven explored changes in emotions since bereavement, and the role of personal beliefs in the management and regulation of emotions since bereavement and during emotional times of year (e.g. anniversaries). Finally, questions eight and nine explored whether the experience of bereavement and the process of ageing and maturing had encouraged existential thinking and questioning (i.e. thinking about one's existence, the meaning and purpose of life, religion/spirituality).

Toward the end of the interview schedule participants were given opportunities to sum up how they felt they had coped during the intervening years, to highlight any resources they would like to have see available to them, and to add any advice they would offer to other people going through the early stages of spousal bereavement. These summing up processes

allowed participants to add any information that may have been missed or overlooked by the previous questions.

Prior to interviews the principal researcher consulted with the counsellor who originally interviewed this sample and with a clinical psychologist on practical issues related to the recruitment and re-interviewing of the sample. Following these discussions items on the interview schedule were reviewed and re-worded to make them as easy to understand as possible. The semi-structured interview schedule was piloted on three older adults known to the researcher who had all experienced bereavement from a spouse who agreed to answer, as best they could, the questions on this "follow-up" interview schedule.

All participant responses to questions on the semi-structured interview were recorded using a Sony TCM-200DV compact cassette recorder.

3.2.4 Procedure

All participants were interviewed individually and on one occasion in their own home. Due to the sensitive nature of bereavement research the interviewer endeavoured from the very beginning to make the participant feel as comfortable and relaxed as possible, and remembered to be empathetic and mindful of the participant's emotional state. Before starting the interview, the interviewer gave a brief personal introduction, explained about the background of the study, and gave a brief overview of the questions to be asked and the four questionnaires to be administered. This was followed by participants completing the informed consent form and being given the opportunity to ask any questions they had.

It was carefully explained to participants that they could withdraw their consent at any time during the interview and that if they became too upset the interview could be paused or terminated at any moment. It was also explained that all information provided would be kept confidential and accessible only by the interviewer, that to preserve participant anonymity personal details would be changed or omitted from interview transcripts and published extracts, and that tapes would be destroyed following transcription and analysis. Before the interview began, the interviewer double checked that the participant was happy to continue.

The overall procedure can be conceptualised into three broad stages; first, completion of the questions on the semi-structured interview schedule; second, completion of the four questionnaires; and finally debriefing and the mood repair component.

3.2.4.1 Semi-Structured Interview

The questions on the semi-structured interview schedule began with the participant talking about their life now and during the intervening years since they were last interviewed and describing any experiences that they had found particularly important and challenging. These questions served as a way of easing the participant in to talking openly and naturally before moving on to more demanding questions and also allowed the participant to get used to the tape recorder. These questions also served the function of furthering the relaxed and friendly atmosphere and maintaining the rapport between interviewer and participant. In addition, responses to these questions also provided a context in which to further understand how the participant had coped and adjusted since last interviewed.

Participants were then asked questions about their personal beliefs and practices, the importance of their beliefs, and the role played by their personal beliefs in accepting, coping, and adjusting to their bereavement. It should be noted that the interview schedule was used flexibly and adapted to fit how each individual participant described their personal beliefs, and their unique experience of coping and adjustment. Furthermore, although questions on the schedule were kept to a pre-defined order, on some occasions the order was changed when participants spontaneously mentioned information relevant to later questions. On these occasions the interviewer followed this information up as naturally as possible as it was mentioned.

Towards the end of each interview the interviewer would summarise participant information in the participant's own words to check that the interviewer had understood and been sensitive to what the participant had said. At the end of each interview all participants were given the opportunity to clarify any information they had given throughout the interview, or add anything they felt was important for the interviewer to know about their experience and had not already been mentioned.

3.2.4.2 Questionnaires

Once the questions on the semi-structured interview were completed, the questionnaire instruments were administered. All participants were offered the opportunity to complete the questionnaires themselves or have the researcher administer them and document participant responses. All participants preferred the researcher to administer and notate participant responses. The geriatric depression scale was administered first, this was followed by the personal meaning index, then the bereavement experiences index, and finally the religious and

spiritual beliefs scale. Following the completion of the questionnaires, participants were verbally debriefed, offered a copy of the debriefing statement, and thanked for their participation.

3.2.4.3 Mood Repair

Following debriefing the interviewer engaged in the mood repair component, a process recommended by clinicians for research of an emotional or sensitive nature. The mood repair component was adapted to fit the tone of the study and age group of participants and therefore took the form of a general conversation with the participant. The mood repair component allowed the interviewer to make sure that the participant was not left in a distressed state by the interview and was left in the same emotional and psychological state that the interviewer encountered the participant. The mood repair conversation involved a general chat with the participant, usually over a cup of tea, and lasting for approximately 15 to 20 minutes. The participant was free to talk about any topics of interest to them, and usually revolved around the topics of current affairs, their children or grandchildren, or their hobbies. This conversation also allowed the participant to ask any questions or to seek any information about any areas discussed during the interview.

Overall, each interview, including completion of the four questionnaire measures and the mood repair component, lasted for approximately 2 to 3 hours.

3.2.5 Analysis

All interviews were transcribed verbatim and in as great a detail as possible noting pauses in speech, word emphasis, repetition, interruptions in speech, turn taking, and expression of emotion (e.g. laughing, crying, sighing, etc.). Also, where appropriate participant non-verbal behaviour, and literary and cultural references were also noted. To preserve participant confidentiality and anonymity, identifying characteristics (e.g. names of people, places) and identifying passages (e.g. details about spouse, family, institutions), were changed or removed from transcripts.

3.2.5.1 Rationale

Thematic analysis was used to analyse interview transcripts. Thematic analysis refers to a qualitative method of data analysis that involves a systematic and organised process of identifying, analysing, describing, and reporting patterns or themes within and across a

particular qualitative data set such as a sample of interview transcripts (Braun & Clarke, 2006; Joffe & Yardley, 2004). Essentially, thematic analysis allows for a large qualitative data set to be analysed in such a way that a set of detailed themes or patterns can be identified that represent or capture meanings that are important across the sample of participants.

The use of thematic analysis was informed by two detailed guides to using this method by Braun and Clarke (2006) and Joffe and Yardley (2004). According to Braun and Clarke (2006), thematic analysis is a technique that is central to many other qualitative methods of analysis such as grounded theory, discourse analysis, and interpretative phenomenological analysis that all share a dedication to searching for and identifying patterns and themes in qualitative data sets. As such, Braun and Clarke (2006) have recommended that researchers interested in using qualitative methods of analysis should learn to use thematic analysis first as it provides the generic skills and foundation for conducting other more theoretically sophisticated methods of qualitative analysis, and therefore is an ideal and easily accessible method for researchers beginning their career in qualitative research methods.

In addition, unlike the other qualitative methods mentioned above that have a specific theoretical or epistemological framework, thematic analysis is much more flexible and can be used from either a realist or constructionist perspective, or somewhere between the two. As Braun and Clarke (2006) have summarised, "thematic analysis can be a method that works both to reflect reality and to unpick or unravel the surface of 'reality'" (p.81). Thus, thematic analysis was considered an appropriate method for the first study of this PhD and an optimal method for exploring and describing in detail the coping and adjustment experiences of this sample.

In the present study thematic analysis was used to identify themes or patterns in coping and adjustment processes used both across the sample as a whole and when the sample was combined into strength of personal belief sub-groups. This latter approach would allow for similarities and differences to be observed in coping and adjustment processes used between sub-groups. More specifically, analysis focused on participant thoughts, feelings, and experiences related to their reality of coping and adjustment and also to the meanings attached to the role played by personal beliefs in the coping and adjustment experience.

3.2.5.2 Process of Analysis

The process of analysis began with interview audio recordings being repeatedly listened to and interview transcripts being carefully checked for their accuracy. This step was followed

by a process of "immersion" within the data that involved repeated reading through of the entire set of interview transcripts in order to increase familiarity with the interview content, to develop a sense of the data's breadth and depth, and to begin the active process of searching for and highlighting initial patterns, meanings, and themes of potential interest (Braun & Clarke, 2006).

This stage was followed by formally coding all of the transcribed data by applying labels line by line and/or by sentence/paragraph categorising and summarising features, segments, and elements within the detailed content. Manifest coding was used to label content that was explicit and directly observable, while latent coding was also used to label content that was inferred or implicitly present (Joffe & Yardley, 2004). Although coding labels utilised were predominantly inductively based, that is data driven and derived from the raw data itself, deductive coding labels influenced by existing theory were also utilised.

Once initial codes had been applied to all the data, codes were then organised, sorted, and merged with similar codes to form potential overarching themes related to the research area of interest. This stage was then followed by a cyclical process of re-reading through the entire set of interview transcripts and refining coding categories and developing themes, and checking themes against the raw data. Once thematic analysis had been applied to the sample as a whole, additional analysis was then conducted to examine coping and adjustment themes that characterised or were specific to each personal belief sub-group. (See Appendix H, Reflexivity section, for researcher reflections related to conducting this first qualitative study).

3.3 Results and Analysis

The following analysis has three main parts. The first part will examine the descriptive and longitudinal quantitative data from the original study and at the follow-up study for the individual participant cases as a whole and when cases are combined into strength of religious/spiritual belief sub-groups (i.e. those with a strong, moderate, and no/weak belief). The second part will then examine the qualitative themes underlying coping and adjustment for the sample as a whole. Finally, the third part will examine the qualitative coping themes that are most characteristic or unique to each belief sub-group.

3.3.1 Descriptive and Longitudinal Data

Table 2 provides an overview of the individual participant scores for the questionnaire measures administered by Coleman, McKiernan, Mills, and Speck (2002, 2007) in their original study in 2000/01 and again during the follow-up study in 2006/07. Consistent with the original table presented by Coleman et al. (2007), participants are ranked according to their strength of religious/spiritual belief score at the final interview of the original study.

Table 2 suggests that there is relative stability in strength of belief scores from the original study to the follow-up study, with participants maintaining either a strong, moderate, or no/weak belief. The one exception is participant 25 who had a score of 21 in her final interview in 2001 and was categorised as having a moderate belief but had a score of 4 in 2007 and was characterised by no/weak belief. Interestingly, the majority of moderate believers (participants, 3, 9, and 11) showed a continual decline in strength of belief score from when first interviewed in 2000 and when interviewed again in 2006/07, while two participants who were originally categorised with a strong belief (participants 8, 14) showed an increase in strength of belief in the follow-up study. With regard to religious practice, all participants who engaged in private prayer in 2000/01 continued to pray in 2006/07, while only one participant (participant 16) had stopped attending regular communal church services. The reasons stated for this non-attendance were functional mobility and transportation difficulties.

With regard to personal meaning, similar to the findings in the original study, high personal meaning scores continued to be associated with higher strength of belief scores at follow-up. Furthermore, scores on depression and grief at follow-up tended to be higher for those characterised by no/weak belief. Interestingly, however, all of the participants characterised with no/weak belief (participants 25, 4, 5, 26) had grief scores in 2006/07 that were lower than when first interviewed in 2000. However, this finding is most likely explained

by the fact that these participants' grief scores were already highly elevated and therefore had more potential to decrease.

Table 3 represents the scores for strength of belief, personal meaning, depression, and grief, by strength of religious/spiritual belief sub-group, estimated for the original study and for the follow-up study. Overall, Table 3 shows that there is a similar pattern of results in the original study and at follow-up. In both studies, the strong belief sub-group tends to have a higher personal meaning score, and lower depression and grief scores compared with the moderate and no/weak belief sub-groups. The no/weak belief sub-group has the lowest personal meaning scores and the highest depression and grief scores in the original study and at follow-up, with the moderate belief sub-group sitting between the two groups on most measures.

From a longitudinal perspective, from the original study to the follow-up study, Table 3 shows that grief scores had lowered for each belief sub-group, and depression scores had lowered for the strong belief and no/weak belief sub-groups. Interestingly, however, it was only the moderate belief sub-group that showed an increase in depression from the original study to follow-up. In addition, only the strong belief sub-group showed an increase in strength of belief and personal meaning from the original study to follow-up, while the moderate and no/weak belief sub-groups showed a decline in strength of belief and personal meaning.

Table 2.

Individual participant scores for original study interviews (2000/01) and for follow-up study interviews (2006/07) on strength of religious/spiritual belief, attendance at communal worship, prayer alone, personal meaning (PMI), depression (GDS), and grief.

	Original Study Scores (2000/01)						Follow-Up Study Scores (2006/07)					
Participant	Belief 1st - 3rd	Worship	Prayer	PMI 2nd	GDS 1st – 3rd	Grief 1st - 3rd	Belief	Worship	Prayer	PMI	GDS	Grief
13	40 – 44	x	x	98	0 – 0	83 – 96	43	x	x	96	0	98
21	43 – 42	x	x	85	2 – 0	83 – 110	41	x	x	90	1	81
14	38 – 38	x	x	97	0 – 0	99 – 69	48	x	x	94	0	78
8	36 – 35	x	x	90	3 – 2	107 – 136	40	x	x	93	0	117
3	43 – 34	x	x	99	0 – 0	106 – 106	33	x	x	94	2	114
9	43 – 33		x	93	3 – 1	114 – 111	27		x	82	2	94
16	31 – 27	x	x	92	4 – 1	138 – 134	31		x	88	1	106
11	30 – 25		x	70	0 – 0	113 – 113	20		x	78	3	114
25	23 – 21		x	50	10 – 12	211 – 217	4		x	61	5	153
4	Pb			83	7 – 1	119 – 142	5			61	5	109
5	Pb			63	3 – 6	160 – 130	6			63	3	147
26	Pb			72	3 – 2	165 – 148	2			66	3	139

* Notes: Pb = Philosophical beliefs. 1st, 2nd, and 3rd refers to data from the 1st, 2nd, or 3rd interview of the original study. Religious/spiritual belief sub-groups = strong belief (13, 21, 14, 8), moderate belief (3, 9, 16, 11), no/weak belief (25, 4, 5, 26). Participant cases: 13 = Rita; 21 = Ralph; 14 = Alison; 8 = Jennifer; 3 = Jean; 9 = Hannah; 16 = Victoria; 11 = Margaret; 25 = Sophie; 4 = Reginald; 5 =Audrey; 26 = Joan.

Table 3.

Means (and standard deviations) for scores on strength of religious/spiritual belief, personal meaning (PMI), depression (GDS), and grief, by religious/spiritual belief sub-group (strong belief, moderate belief, no/weak belief) for original study and follow-up study.

Religious/Spiritual Belief Sub-Group	Strength of Belief	PMI	GDS	Grief
ORIGINAL STUDY (2000/01)				
Strong (n = 4)	39.8 (4.0)	92.5 (6.1)	0.5 (1.0)	102.8 (27.9)
Moderate (n = 4)	29.7 (4.4)	88.5 (12.7)	0.5 (0.6)	116 (12.4)
No/weak (n = 4)	Pb	67.0 (14.0)	5.3 (5.0)	159.3 (39.2)
FOLLOW-UP STUDY (2006/07)				
Strong (n = 4)	43.0 (3.6)	93.3 (2.5)	0.25 (0.5)	93.5 (18.0)
Moderate (n = 4)	27.8 (5.7)	85.5 (7)	2 (0.8)	107 (9.5)
No/weak (n = 4)	4.3 (1.7)	62.8 (2.4)	4 (1.2)	137 (19.5)

*Notes: Pb = Philosophical beliefs.

3.3.2 Qualitative Analysis

The interview data provided a wealth of information about a wide range of issues, including experiences of coping and adjusting to loss-and-restoration-oriented stressors; thoughts on religion, human nature, and current affairs; and issues related to ageing and growing older alone. However, during the process of analysis data related to coping and adjustment since last interviewed and the role played by personal beliefs were foregrounded and considered in detail. During analysis where appropriate verbal extracts are given to illustrate, elucidate, and support themes. The following notation (…) represents a pause in speech, while (. . .) represents omissions from original text; where necessary words in square brackets [] provide clarification about the subject or activity the participant is discussing. Following a quotation the name of the participant is supplied and line numbers from where in the interview transcript the quotation is taken from, for example (Roger, L.845-847).

3.3.3 Overall Sample

The sample as a whole described variations in coping and personal beliefs, and was a sample that at approximately the seven and a half year point following spousal bereavement was still actively engaged in coping and adjusting on a day-to-day basis. In addition to coping

with spousal bereavement, other challenging issues that this follow-up sample had experienced since last interviewed included moving home, the development or worsening of a chronic illness, undergoing minor and major surgery, witnessing family divorce, and experiencing bereavements of close friends and relatives. More positively, many had seen new grandchildren and great-grandchildren born into the family, seen family marriage, gone on foreign holidays, and one participant had travelled by aeroplane for the first time. In addition, some participants described experiencing post-bereavement gains in confidence, self-reliance, and independence.

With regard to day-to-day coping, the majority of participants found that weekends and evenings were the most challenging times with loneliness or boredom the most common problems, while the winter months with fewer daylight hours were expressed as a more difficult time than spring and summer months. Nearly every participant mentioned the importance of keeping busy, keeping mentally active, and having several hobbies or interests.

The coping themes that seemed important for the sample as a whole were: (i) downward comparisons and benefit finding; (ii) social support from family; and (iii) personal beliefs.

3.3.3.1 Downward Comparisons and Benefit Finding

This first theme represents two separate processes, downward comparisons and benefit finding, which appeared to produce the similar effect of encouraging a broader more positive perspective of one's bereavement to be taken. Furthermore, these processes seemed to encourage gradual cognitive acceptance including seeing one's suffering as "part and parcel of life" and encouraged positive emotions in the form of being thankful or grateful.

The first process, downward comparisons, involved participants comparing their own circumstances with the circumstances of others perceived as being worse off. For example, nearly every participant knew of or had contact with others who were suffering from either Alzheimer's disease, dementia, or a terminal illness, and participants commented that in comparison with these people their own suffering seemed less negative.

> The thing you must remember, there's always somebody out there who is much worse off than you are, you know. Like that poor chap there, Richard [*friend's husband in hospital with a terminal illness*], he is fighting for his life now as we speak now, so you think about these things (Sophie, L.271-274).

The second process, benefit finding, involved participants being able to identify something positive in their experience of loss and that this provided some sense of consolation.

Interestingly, the most frequently identified benefit was that their spouse was no longer suffering.

> I mean obviously the anniversary of the day he died you know, you feel a little bit sad and then you think 'well you know he wasn't very well at the end and you couldn't have wished for him to be here suffering so therefore in that way', I think that helps the fact that you think to yourself 'well he's not suffering any more' you know and umm that does help you to sort of accept that he had to go (Jennifer, L.580-584).

3.3.3.2 Social Support from Family

Perhaps unsurprisingly, social support from family, specifically adult children, was expressed as a primary coping resource for the majority of participants. Social support from family seemed to be important just by its perceived availability and presence during every stage of the grief process rather than for anything more specific. However, some participants did comment that they had continued to talk about, and work through, their thoughts and feelings with their family and that the family had been like "a rock", thus suggesting stability and continuity. In this respect it was perhaps the emotional support received from family that was perceived as most valuable. In addition, the positive feedback that participants received from family on how they were coping also seemed to bolster perceived ability to cope. Alison, 90 years old, captured some of these elements in her descriptions of social support from her family:

> I mean we're not a very big family but we're very close and so that, I've had all their support and after all they lost their father and that was a great blow for all of the three children you know to have lost their father suddenly like that but I mean they surrounded me as though it was just me that was suffering I mean they were wonderful really (L.294-298). . .I mean I think the family think I've coped wonderfully, and umm I think you know they say 'oh mum you're marvellous', so marvellous mum goes on (*laughs*) (L.1071-1073).

An additional aspect of social support from family that seemed particularly important was in the immediate assistance that adult children could provide to participants coping with either restoration or loss-oriented stressors should it be required. Indeed, one of the most frequently mentioned benefits of social support from family was in combating feelings of loneliness.

> You know if I'm feeling a bit lonely I only have to pick up the phone and somebody comes and picks me up (Hannah, L.80-81).

3.3.3.3 Personal Beliefs

Nearly every participant described having some kind of personal belief that they used to make sense of and understand the world around them, other people, and human nature in general. For two-thirds of the sample this was a Christian belief, while for one-third this was more of a philosophy of life based on the importance of humanistic values such as decency and respect. Participant personal beliefs are discussed in more detail below.

Although for those who placed less importance in a Christian belief other factors such as social support from family was the primary coping resource, for those with a strong Christian belief in which the belief was held with considerable importance this strong belief was the primary resource in coping.

> As I say it is your beliefs that help you to keep going and to cope with everything. As I say friends and family are very important but I think also you need something more than that, you need to feel there is something greater than that to help you (Jennifer, L.393-395).

Furthermore, in the present sample, a Christian personal belief seemed to be important in providing continued meaning to life, optimism, and perhaps most importantly hope.

> I think if you didn't have a belief it would all seem so final and you would think 'what is there to live for?' you know, but the fact that you do believe you know it helps you to keep going (Jennifer, L.323-325).

3.3.4 Strong Belief

The strong belief sub-group was characterised by a traditional Christian belief involving belief in a personal God or higher power, and belief in the divinity and teachings of Jesus Christ. Denominational membership was predominantly Church of England, and religious practice included at least weekly church attendance, daily prayer, and reading the Bible. Participants believed that God had the power to intervene into human affairs but that essentially humans had free will to act as they choose. In keeping with Christian teachings, all participants in this group emphasised the importance of actively helping other people. All participants in this sub-group remarked that their religious belief had helped them in coping and adjusting to their bereavement and that they could not imagine coping without their religious belief.

The strong belief sub-group articulated few if any problems in coping and adjusting to their bereavement in the intervening years. The most significant restoration-oriented difficulties involved needing support with household chores and gardening, while loss-oriented

problems involved occasional loneliness or missing their partner. Those with a strong belief described few if any symptoms of depression or grief and this was supported by low scores on the GDS and BEI. Most of the participants in this sub-group remarked that the coping and adjustment process during the intervening years had posed no significant difficulties for them, that their present life circumstances were good, and that they had an enjoyment for life. Indeed, these latter findings were supported by high scores on the PMI.

The personal belief themes that seemed to underlie coping for this sub-group included: (i) faith in an afterlife; (ii) a sense of providence; (iii) confidence in prayer; and (iv) support from the church.

3.3.4.1 Faith in an Afterlife

For participants with a strong religious belief one of the most important Christian beliefs related to coping was belief in an afterlife of some description. Indeed, all of the participants in this sub-group believed in an afterlife.

> I mean your strongest belief is hoping that there is an afterlife and you will meet your husband again, you know you will meet your loved ones again, I think that's the thing that keeps you going (Jennifer, L.99-101).

Furthermore, belief in an afterlife seemed to prevent participants from thinking that bereavement marked the end of their relationship with their spouse or that they would never see their spouse again, and thus perhaps buffering against any harmful effects that would be caused by dwelling on the finality of death.

> I think if you felt 'oh dear I'll never see them again or that's the end' that would be absolutely dreadful, I can't imagine what that's like, and you just think 'oh well he's just gone on ahead of me' umm and so yes you've got the loss to cope with but umm it's not a loss where you think that's the end (Alison, L.141-144).

In addition, it was also important for participants to believe that they would eventually meet again their spouse and other significant lost loved ones.

> As far as I'm concerned he's gone to a better land, and I sincerely hope that I will meet him, my mother and father, my, all my family has gone bar me now, and all his family has gone, so it's only me left of my family, and I believe that one day we shall meet again (Rita, L.523-526).

In coping terms, belief in an afterlife and of eventual reunion allowed participants to reinterpret one aspect of their bereavement, namely the finality of death, in a less threatening, more hopeful and comforting way.

3.3.4.2 Sense of Providence

An additionally important belief for this sub-group was related to participants' sense of the omnipresence of God. In different ways, all participants described a sense of the constant presence of God in the "background" of their lives.

> I would say to you He's the only one that's there for us every particle of every day (Rita, L.229-230).

In addition, this sense of the close presence of God helped buffer against common loss-oriented stressors such as feelings of loneliness. Indeed, none of the participants in this sub-group highlighted loneliness as a particular problem.

> I mean it does help me not to feel lonely, I feel there is somebody there, intangible but something there, a providence of some sort, umm…Yes it's a very comforting thing to have a faith, I sometimes feel that those who haven't are missing out a lot (Ralph, L.352-355).

Importantly, based on this sense of the omnipresence of God was a belief that was particularly characteristic of this group, namely the belief that God was in some way looking after and protecting participants and helping them throughout their lives.

> Just the fact that there is something there and umm you know somebody there who is watching over you and umm helping you through all this. I mean I never thought, it's nearly eight years now, eight years in March, I never thought that I could cope eight years without him you know - but you do (Jennifer, L.332-336).

Furthermore, all of the participants in this sub-group felt they could turn to God for help in times of need.

> The feeling that…God is there in the background all the time, He's, He's watching over you and that you feel you could turn to Him I think mainly in prayer when you need Him (Jennifer, L.247-249).

3.3.4.3 Confidence in Prayer

Related to a sense of providence was the use of prayer as a mechanism for expressing and allaying any worries or fears participants had, and having confidence in the effectiveness of their prayers.

> Mainly I say the same prayers every night but if something is worrying you, you'll add that into your prayers you know 'Oh Lord, please will you help me on such and such,' you know, 'I'm worried about this can you help me?' (Jennifer, L.221-223).

Practical examples of participants' use of prayer were related to stressful experiences such as undergoing surgery. In discussing his forthcoming cataract operation, 85 year old Ralph described how he would use prayer:

> Oh yes I would ask Him [God]…pray that He would see that everything went through satisfactory, umm and I would have that confidence that He would help me in that regard (L.516-518).

In addition, Rita, 77 years old, described the importance of prayer immediately before she underwent surgery for breast cancer. Not only was there the belief that God had the power to influence events but that her prayers could be used to appeal to deceased loved ones such as her husband and parents for protection. This use of prayer highlighted the belief in this sub-group that those who previously played a caring role in the life of the participant, although now deceased, still have the power to help the living.

> Well when I was having my operation. . .as I lay there and I'd say, I say 'well this is it you know, I'm in your hands now'. As I say with that cancer, I said to my niece 'well the only time I'll get worried is when I'm on that table going into the room' and she said 'I should think you would'. But when I lay there and I get a bit worried and then I take one deep breath and I just say 'please stay with me', and that's all I do, and I will say to my husband and my mother and father 'just be there with me' (L.584-590).

3.3.4.4 Support from the Church

Although most of the participants in this sub-group had not required any major practical support or assistance from their local church (i.e. from ministers or fellow members) in coping and adjusting to their bereavement, all acknowledged the importance of perceived access to support should they need it. In addition, many of the participants remarked that they found the moral and emotional support they received from the church particularly comforting during

times of illness or following surgery. In discussing a previous cataract operation, in the absence of available close family, Ralph highlighted the practical assistance he received from his local vicar:

> When I had this cataract out last October, when you have a cataract operation done you're always told not to be on your own the next night, always have company. Well umm he [the vicar] immediately and his wife said you must come to us afterwards, and he came to the hospital after the operation and took me back to the vicarage and I spent the night there and they brought me back here the next day (L.433-438).

3.3.5 No/weak Belief

The no/weak belief sub-group was characterised predominantly by a secular belief although one participant did express a "very vague" spiritual belief influenced by Judaism, the religion that had been important to her husband and that had taken on more importance to her since last interviewed. However, this participant found little or no comfort in the idea of a God or afterlife. The personal beliefs that were expressed as important for this sub-group were humanistic in nature and emphasised the values of honesty, decency, forgiveness, altruism, chivalry, the importance of family life, and being good to one's neighbour. Although not strongly hostile toward religion and Christianity specifically some participants did express a disbelief influenced by negative past life events including illness and bereavement and negative experiences with the church. Some of the participants were sceptical about aspects of Christianity such as the concept of the resurrection and questioned how a loving God could allow unnecessary suffering. Interestingly, however, instead of apathy or indifference toward Christianity some of the participants, perhaps because of their Christian upbringing, had come to interpret and understand Christianity from a humanistic rather than a spiritual perspective.

> You know to me Christianity is helping one another, it's not anything spiritual (Joan, L.246-247).

Moreover, despite having doubts and being sceptical about some of the claims within Christianity there was also an appreciation for some of the teachings and how these were relevant to daily living.

> I've never been a big believer myself, I've always (*laughs*) uhh…religion is a funny subject you know to me umm, I just can't get over the fact that you know some of the things that went on, or supposedly went on, you know just by logic couldn't have happened you know. But I'm a big believer in the teachings, you

> know the Ten Commandments is what we live by anyway, or should live by you know and it's a very good system to live by (Reginald, L.314-319).

The no/weak belief sub-group described coping and adjustment during the intervening years marked by a fluctuation between opposite ends of the coping spectrum. At one end, participants indicated occasional difficulties in restoration-oriented coping with regard to house maintenance, gardening, and cooking, and significant difficulties in loss-oriented coping involving chronic grief, depression, anger, cynicism, loss of trust in other people, ruminating about the circumstances of the bereavement, suicidal thoughts, and a preoccupation with death. In addition, one participant had received counselling and had been prescribed anti-depressants since last interviewed. These findings were supported by the highest scores of the three sub-groups on the GDS and BEI and the lowest score on the PMI.

> Some days I'm very depressed and I can't see anything good. I think a lot about death which I never used to think about death before, but…having seen you know it at close hand I think about it a lot (Sophie, L.56-58).

However, in contrast, at the opposite end of the coping spectrum, participants also described indicators of clear progress being made in coping including significant anniversaries becoming more manageable and being less sensitive to grief triggers. Joan, 68 years old, provided an example of this progress. Joan had lost her husband shortly after Christmas and had found every Christmas since her bereavement an upsetting and difficult time of year.

> This is the first year that I can say that I not only enjoyed Christmas, I enjoyed the build up to it whereas other years I've hated it, I've gone through the motions and as I say for other people but this year I found I quite enjoyed it (L.916-918).

The coping themes that seemed unique to this sub-group included: (i) taking each day at a time, (ii) hiding and masking grief; and (iii) determination and motivation to cope.

3.3.5.1 Taking Each Day at a Time

All of the participants in this sub-group emphasised the importance of coping by taking each day at a time and this was a strategy that seemed to allow participants some control over their life and grief. In addition, using this strategy allowed participants to focus on enhancing positive thoughts and feelings and minimising negative ones. This strategy also encouraged participants to be more spontaneous and to engage in pleasurable activities whenever possible that might bring respite from grief.

> Well I always think it's a case of taking a day at a time, umm and do what's best for you on a day-to-day basis, I'm not, I'm not saying be selfish but if you can do something during that day that makes you feel a bit easier in yourself then go ahead and do it and break from your normal routine (Audrey, L.974-977).

However, for others, taking each day at a time was important because it prevented participants from looking too far ahead into an uncertain future. This reluctance to look too far ahead was partly because future aspirations had likely changed since bereavement and thinking about these disappointments may trigger further upset but also because looking too far ahead might induce worry or anxiety. Indeed, some participants in this sub-group expressed concerns about becoming too unwell in the future to be able to cope independently and about the perceived closer proximity of death. Thus in order to minimise further emotional upset it was more productive for participants to focus on the here and now and to be thankful for the good things that each new day brought.

> The only way to cope is to take a day at a time really, when I say put your blinkers on, and focus, like sometimes I feel better because, say I got something unexpected in the post, a real nice letter, or somebody, a nice word of thanks or something, or something good happened, and I say 'golly this is really nice' so I say to myself 'well today I've already had two good things happen' and you know that is the only way to focus, I'm convinced of that, because if you try to imagine 'oh my gosh what is going to happen in the future' it's so terrifying, it could be so terrifying that you know it could have a terrible effect on your morale (Sophie, L.1177-1185)..

3.3.5.2 Hiding and Masking Grief

A different coping strategy described was of hiding and masking one's grief. This "putting on a brave face for other people" highlights an aspect of coping and adjustment seldom mentioned in the theoretical literature, namely of a sense of self-consciousness in the bereaved about how they are perceived by those around them. This increased vigilance about how one is perceived can lead the bereaved to behave in a manner incongruent with how they really think or feel. Indeed, use of this strategy seemed to be a hangover from behaviour in the early stages of bereavement whereby hiding one's grief was used as a way of not hindering the progress of other people such as adult children who may also be grieving and in an attempt to avoid embarrassing well-meaning others offering sentiments of condolence. In the context of the present sample, the necessity of having to use such a strategy suggested that after a certain period of time some participants had felt a pressure from people around them to appear as if they had returned to a state of normality.

> I think a lot of people around me they don't realise the extent of how I feel sometimes because I don't make that visible any more. In the first stages of you know bereavement I think people could see it but now I'm much umm more umm…more of an actress shall we say to mask it, when I don't want to upset other people (Audrey, L.386-390).

Furthermore, there was also an aspect of this strategy whereby through the habit of repeatedly hiding and masking grief from family and friends this endeavour had begun to influence how one was actually coping and adjusting, and perhaps increasing the perception that they were coping well.

> To begin with you're trying to cope and you're doing everything in your power to cope and as I say you're putting on a brave face for other people, and then it comes a time where it's worked for you, yeah you've got there (Joan, L.551-553).

3.3.5.3 Determination and Motivation

An additional strategy used by this sub-group was of determination and motivation to cope. This theme attempts to capture how at some point during the coping process participants in this sub-group had at some level made an explicit or tacit decision that they needed to bolster their coping and adjustment efforts. Often this determination or motivation was precipitated by an unpleasant event such as an illness or by something important in the individual's life such as their family.

> I was very ill at one stage after I took part in the first interviews umm and I think probably that was a turning point for me, it sort of made me think more that I had to pull myself together, you know, to umm still be there for my family (Audrey, L.8-11).

Interestingly, participants in this sub-group described reminiscing about how people coped during the First and Second World Wars and about the coping experiences of parents and grandparents. These sources provided useful exemplars of coping and at a latent level seemed to encourage determination and motivation to cope.

3.3.6 Moderate Belief

The moderate belief sub-group was characterised by varying levels of religious uncertainty and by a belief system supported by very few religious details. All of the participants in this sub-group described their denomination as Church of England but described

attending church services infrequently or not at all. Furthermore, no participants were presently reading the Bible or any other religious scripture. A particularly noticeable feature of this group was the varying attitudes about belief in God, ranging from belief in a God of some description but not necessarily a personal God to uncertainty about the existence of God. Interestingly, however, nearly all of the participants in this sub-group prayed on a daily basis, with all using prayer to some degree. One particularly notable participant was Margaret, 83 years old, who articulated an interesting contradiction in being uncertain about the existence of God yet praying every morning and evening ever since childhood. Margaret described her uncertainty in God as follows:

> Well I don't know, I mean they only say there's one God, I haven't, I'm not a firm believer but you've got to be a bit of umm, well you've got to be a bit hopeful and believe a little…I can't say I'm a firm believer. I say to myself He does miracles in one way and yet why do He let other young children suffer who have never done a thing wrong and that sort of thing, so it sort of, I query one against the other (L.53-58).

In addition, this sub-group was also noticeable for its uncertainty related to belief in an afterlife. Hannah, 72 years old, described her uncertainty about an afterlife as follows:

> I'm not too sure about that one. I, I, who knows, we don't know do we, none of us know, but umm, no I'm not sure, I'd like to think so, yeah, I'm not afraid of dying or anything like that, but umm, it would be nice to think that I could meet everybody when I go, but like I say, I'm not sure (L.343-346).

Although for this sub-group their Church of England religious belief was held with some importance and had been of some assistance in coping, it was perhaps not as important to coping as support from close family and friends.

> I think I'm very lucky to have what I call 'old friends, close friends, and family', without all that I don't know how I would cope, not only just believing but I think friends and family have helped as well (Victoria, L.820-822).

The moderate belief sub-group articulated few problems with restoration-oriented adjustment but described loss-oriented problems in coping marked by occasional depression, loneliness, and crying.

> Well some days I could cry all day umm…really I just can't control it and umm and then you know, you know that's not going to do any good and so you have to umm, what I call 'shake yourself out of it' and stop being so silly, you know,

> try to umm, you just have to go on, but some days are terrible (Victoria, L.660-663).

In addition, participants in this sub-group also expressed difficulties in attending social functions alone, adjusting to being an individual rather than part of a couple, and seeing other couples together. Significant anniversaries such as their spouse's birthday, their wedding anniversary, and the date of their spouse's death were also described in different ways as difficult. Similar to the no/weak belief sub-group, moderate believers also described coping involving "putting on a brave face":

> No I do get a bit upset at times yeah, but, when I think about it all and that you know I sort of put a brave face on, you know I seem to be able to and that. I don't always let people know what my feelings are (Jean, L.1085-1087).

As well as describing coping involving "taking each day at a time":

> I learnt like now to live each day as each day comes along, I can't plan, I never plan ahead…and I think that's what just helps is just accepting each day as it comes along (Margaret, L.408-410)

The coping themes that appeared unique to this sub-group included: (i) Understanding bereavement as a consequence of fate; and (ii) coping through one's generative role in the family.

3.3.6.1 Bereavement as a Consequence of Fate

For the moderate belief sub-group, the role of fate, that is the belief that events occur outside of an individual's control in a predetermined way, seemed to be an important way of understanding one's bereavement and provided an adequate explanation. Moreover, these attributions to fate as an explanation for bereavement seemed to have developed gradually with time since bereavement. Victoria, 70 years old, captures aspects of this move toward accepting fate as an explanation in her description:

> When my husband died first you sort of think umm 'why?' You know, 'is there a God if He's taken my Gordon' because umm…there's so many bad people and so why does He take the good people? So it does what I call 'shake your religion' for a bit but then that doesn't last long because that is silly because you know we don't know the reasons why but that you can't start saying 'I blame God'. . .You can't umm blame other people or God or anything for what happens. It's perhaps destiny or what is meant to be, I don't know the reason why, I wish it hadn't happened but it did (L.104-116). . .I just come to terms that it must have been fate, you know not, not something that…I think perhaps from

> the minute you are born your destiny, your fate we don't know what controls it but perhaps it was meant to be (L.194-197).

The explanation for why moderate believers may place emphasis on the role of fate is perhaps related to having an uncertain religious belief. Attributions of the bereavement to fate may protect an uncertain belief from being made even more uncertain, and thus allowing for the bereavement to be unrelated to the existence of God. Indeed, attributions to fate may be easier to accept compared with the idea of a God who allows pain and suffering to occur. Alternatively, attributions to fate may provide a cognitive explanation that requires little further justification, elaboration, or understanding, and a way that perhaps brings searching for an answer to a state of closure. Nevertheless, attributions to fate seemed a characteristic of coping by those with a moderate or uncertain religious belief.

3.3.6.2 Generative Role in the Family

All participants in the moderate belief sub-group were female and all had children, grandchildren, and some great-grandchildren who lived nearby and visited daily. Since the experience of their bereavement all participants had become very involved with these family members and played a primary role in the ongoing lives of the younger family members. Indeed, playing a generative role in the life of the ongoing family provided motivation to cope and continue living. As Hannah described:

> If I'd been on my own I think I would have crumbled to be honest, yeah. . .I wouldn't have seen I suppose any purpose...because you know you've got to have something to live for (L.515-520). . .I mean for a little while after Harry's death I did wonder what do I do now, but I've got a family haven't I so that was soon answered (L.928-930).

Participants expressed much concern, interest, and involvement with these younger generations and expressed a "need to be needed" by the younger generations of the family. Participants described a range of generative activities that they were engaged in, including: discussing homework, preparing meals, collecting from school, and babysitting for grandchildren, and doing household chores for children.

In addition, participants were also concerned with how they might be perceived by their children and expressed concern about wanting to leave their children with a good memory of them.

> I like to feel when something happens to me, when I pass on, that the children would have a good memory of me and that they would follow my, well try and follow my foot steps to do the right things (Jean, L.824-826).

This generative interest and concern for the younger generations of the family seemed to facilitate coping by providing ongoing meaning, purpose, and structure to daily living, but also motivated participants to set positive examples for the younger generations of their family.

3.4 Discussion

The aim of the present study was to follow-up survivors from a previous longitudinal study of spousal bereavement and personal beliefs by Coleman, McKiernan, Mills, and Speck (2002, 2007) and to investigate how participants had coped and adjusted in the longer term since last interviewed. Furthermore, in the present study it was possible to explore the strategies, techniques, and resources used in coping and adjustment for the sample as a whole and when participants were combined into strength of belief sub-groups (i.e. strong, moderate, and no/weak belief), consistent with how participants were categorised in the original study.

The qualitative analysis of participant interviews revealed that far from longer term coping in the post-bereavement years being a passive or accomplished process, these participants were still using a diverse range of coping processes on a day-to-day basis. Although the sample seemed to have adjusted well to restoration-oriented stressors such as dealing with finances, household chores, and house and garden maintenance, the loss-oriented stressors such as living alone, managing grief, and being an individual rather than part of a couple, had proven more challenging. Participants described both their successes and their continuing difficulties.

These successes and difficulties in coping were particularly revealing when participants were combined into strength of belief sub-groups. Perhaps one of the most striking features to emerge from this analysis was that in comparison with the strong belief sub-group who described relatively few difficulties in coping or adjustment, the no/weak belief sub-group described considerable difficulties involving characteristics of depression and chronic grief. These descriptions of more difficult coping were supported not only by high scores on the GDS and BEI, and low scores on the PMI, but also by the type of coping themes that seemed most characteristic of this sub-group (i.e. taking each day at a time, hiding and masking grief, and determination and motivation). These themes reflected much more of a struggle in longer term coping, with participants coping more for other people than for themselves, coping with little optimism or hope for the future, and perhaps most disturbingly hiding and masking their grief from those around them. This latter finding suggested that for some bereaved older adults there may be a reluctance to really express how they feel for fear of upsetting family or friends, and that there may be many more bereaved older adults in the wider population who unbeknown to their families may be secretly suffering in silence many years after their bereavement.

The findings that the strong belief sub-group described few problems in coping and adjustment and had the lowest scores on the GDS and BEI, and the highest scores on the PMI

are consistent with the growing body of research demonstrating a positive influence of religion on coping with bereavement (Wortmann & Park, 2008, 2009). In the present study the explanation offered for these findings is that it may not necessarily be a strong religious belief per se that was beneficial to participants in the strong belief sub-group but rather the coherence and content of their personal belief that was useful. The strong belief sub-group had a coherent personal belief system (i.e. Christianity) that contained content that could be directly applied to the issue of bereavement. In contrast, it was noticeable that the no/weak belief sub-group did not have a coherent atheistic or agnostic belief system but rather these participants placed importance in a set of humanistic values that had little or no influence in explaining or providing meaning or consolation about bereavement. In keeping with this line of thought, those with a moderate belief sat somewhere in between these two sub-groups, having access to a coherent belief system but expressing doubt or uncertainty in its content. Thus, with regard to the role of personal beliefs in coping with bereavement, the present findings suggest that both coherence and content are likely to be important.

If a strong coherent personal belief be considered as an internal coping resource, as a way of assimilating bereavement within a personally meaningful framework or schema of understanding the world, then perhaps social support from family is best considered an external coping resource well suited to dealing with the more tangible aspects of bereavement such as providing physical assistance or companionship. In the present study it could be discerned that family as a coping resource exerted multiple influences on coping and adjustment, for example in the provision of emotional and instrumental support, in offering opportunities for generativity, and in inspiring determination and motivation to cope. However, the finding that some participants preferred to hide and mask their grief from family members suggests that for some bereaved older adults the presence of family in the coping process can be negative as well as positive. As such, the specific role of family alone and the support family provide in coping and adjusting to bereavement should be explored in more depth in future research.

A potential implication of the present study is that it suggests possible risk factors for more problematic longer term coping and adjustment during the post-bereavement years. Risk factors for poorer coping and adjustment may include: having little or no access to support from family; possessing a personal belief system with little coherence or relevant applicable content; being unable to use or find comfort in generic strategies such as down comparisons and benefit finding; and being unable to traverse between using multiple strategies and resources.

However, these potential risk factors are suggested tentatively and require confirmation in future research.

In evaluating the present findings there are a number of limitations that should be considered. One limitation is that the follow-up sample may not be a good representation of the original sample used by Coleman, McKiernan, Mills, and Speck (2002, 2007). More specifically, it is notable that those participants in the original study with a strong atheist belief, who seemed to be coping well and who scored low on depression and grief, and who scored highly on personal meaning in life, did not take part in the follow-up study. Furthermore, none of the participants in the present study categorised as having no/weak belief articulated a strong or coherent atheist or humanist belief.

A related limitation is that the participants who agreed to take part in this follow-up study may not necessarily be representative of the wider population of older adults. Indeed, it could be argued that regardless of variations in strength of personal belief within the present sample one underlying characteristic that all participants may share in common is that of being resilient in the face of adversity and possessing the ability to endure adverse negative life events. If so, the present study suggests that one important characteristic of resilience in later life may be the ability to be able to use multiple strategies and resources in coping and adjusting to age-related challenges.

An additional limitation that deserves mention is of the method used to categorise participants as having a strong, moderate, or no/weak belief. Although the method used was the same as in the original study by Coleman, McKiernan, Mills, and Speck (2002, 2007) it is perhaps too crude particularly with regard to categorising those with a moderate belief. Indeed, the moderate belief sub-group was the most difficult group to characterise and describe mainly because this sub-group covered a large terrain ranging from those with a low or weak belief to those verging on having a strong coherent belief. Thus, this sub-group showed signs of using strategies of both the strong and no/weak belief sub-groups.

3.4.1 Summary

In summary, the present study has identified a range of different strategies, techniques, and resources that bereaved older adults may be likely to use in longer term coping and adjustment. Personal beliefs may be one such resource but may only be effective when there is certainty in the belief, when the belief system is coherent, and when the belief system has relevant content to the coping situation. In the present study, those with a strong Christian belief were able to draw on distinctive aspects of their faith and practice and this seemed to

contribute toward facilitating coping and adjustment. Study Two (see Chapter 4) now aims to investigate in more detail the specific Christian content and practice that is most important to older adults with a strong Christian belief in coping with spousal bereavement, and to explore how this content and practice is used.

Chapter 4
Religious Content and Practice in Meaning Reconstruction and Coping with Spousal Bereavement in Older Adults

4.1 Introduction

Although research has shown that religion can have a positive influence on bereavement outcome (Becker et al. 2007; Wortmann & Park, 2008, 2009; see section 2.5), very little research has identified the religious content that may underlie religion's influence. Indeed, much of the research has tended to treat religion as a singular construct with little attention paid to the underlying beliefs, experiences, and practices that make up religion or spirituality. In addition, very little research has explored how religious belief and behaviour are actually used in coping with bereavement, or to quote Matthews and Marwit (2006) how religious belief and practice are "translated and converted into specific forms of coping" (p.94).

Therefore, the aim of the present study was to identify the specific content of Christian belief and practice (i.e. religious cognition and behaviour) involved in coping with spousal bereavement in older adults, and to examine how this content translates into specific modes of coping. As part of this process the study also aimed to investigate how the salient content of religious belief and practice are involved in meaning reconstruction (i.e. sense making, benefit finding, and identity change), the processes considered to be central to grieving (Gillies & Neimeyer, 2006; Mathews & Marwit, 2006; Neimeyer, 2001; see section 1.14).

4.1.1 Religious Belief and Practice

The existing research on religion and bereavement suggests that both belief and practice dimensions can have a positive influence on bereavement adjustment, even though there are sometimes inconsistencies in the findings. In addition, a number of more recent studies have shown a much more dedicated approach to examining the influence of religion on the experience of bereavement. One such example of this more dedicated approach is by Fry (2001) who examined the influence of a range of "existential" variables in predicting psychological well-being in a cross-sectional study of older adults, aged 65 to 87 years, who had lost a spouse in the previous 24 months. Amongst the religious/spiritual variables that were identified as predictors of psychological well-being were spiritual beliefs and practices, importance of religion, accessibility to religious support, and comfort from religion. Interestingly, however, participation in organised religion remained non-significant throughout the analyses conducted by Fry (2001).

A similar dedicated study is that of Brown, Nesse, House, and Utz (2004) who using older adults from the Changing Lives of Older Couples longitudinal project examined changes in religious belief and church attendance following spousal bereavement and the influence of these changes in religiosity on grief. In their prospective study, Brown et al. (2004) found that following spousal bereavement, bereaved older adults, compared with age-matched controls, showed an increase in the importance of their religious belief and church attendance. Furthermore, the increase in importance of religious belief was associated with a reduction in grief for up to 48 months compared with widows who did not show an increase in importance of religious belief. In contrast, older adults who showed an increase in church attendance did not differ in their level of grief throughout follow-up compared with widows who did not show an increase in church attendance. Brown et al. concluded that these findings suggested a significant difference between religious belief and church attendance on coping, with religious belief appearing more beneficial for the bereaved than church attendance. Interestingly, however, the findings revealed that increased importance of religious belief returned to near baseline by 18 months post-bereavement while church attendance remained elevated for up to 48 months post-loss suggesting that participants may have found some benefit from church attendance unrelated to directly reducing their grief.

Indeed, a series of other studies that have included older adults have found that church attendance and religious involvement are associated with several indicators of improved bereavement adjustment. For example, a study by Carr (2004) using African American older adults who had experienced spousal loss, found that regular church attendance was a predictor of lower post-bereavement anger. Furthermore, in an earlier study by McGloshen and O'Bryant (1988) using older widows who had lost a husband, church attendance was a predictor of increased positive affect. In addition, several other studies have found church attendance to be related to lower levels of depression (Bornstein, Clayton, Halikas, Maurice, & Robins, 1973; Higgins, 2002; Siegel & Kuykendall, 1990), and in bereaved parents related to lower levels of death anxiety, anger, and guilt (Bohannon, 1991).

One conclusion that can be drawn from the above research findings is that belief and practice can both be experienced as beneficial but importantly that they may be beneficial in different ways. Religious belief is likely to offer particular ways of thinking about and processing the loss, while religious attendance may offer access to activities or sources of religious meaning that may be helpful during the grieving process.

4.1.2 Content of Religious Belief and Practice

It can be discerned from the religion and bereavement literature that a specific religious belief considered to be particularly influential on coping with bereavement is belief in an afterlife. Indeed, a focus on this belief marks an attempt in the research to identify the more specific content underlying religion's influence. Belief in an afterlife is theorised to be influential because it can provide solace or hope for the future (Frantz, Trolley, & Johll, 1996; Smith, Range, & Ulmer, 1992), and is likely to be used in positive reinterpretations or reframing of the bereavement in a more comforting way (Clarke, Hayslip, Edmondson, & Guarnaccia, 2003; Pargament, 1997). However, the empirical research that has investigated the influence of afterlife belief has produced mixed findings.

For example, in one study of bereaved participants aged 16 to 86 years, Smith, Range, and Ulmer (1992) found that those with a strong belief in an afterlife showed better bereavement adjustment compared with those with a low belief in an afterlife, regardless of the characteristics of the cause of death related to the bereavement. However, in a more recent study of bereaved adults aged 18 to 88 years by Clarke, Hayslip, Edmondson, and Guarnaccia (2003), these researchers found no influence of belief in an afterlife on bereavement adjustment. Indeed, Clarke et al. (2003) concluded that belief in an afterlife may be more important when faced with one's own death than the death of a loved one. Thus it seems that the influence of belief in an afterlife is still not well understood in the context of coping with bereavement.

Arguably one of the most insightful studies with regard to identifying the varying content of religious belief and practice used in coping with bereavement is by Frantz, Trolley, and Johll (1996). Using a sample of 312 adults, aged 15 to 83 years, who had experienced a significant bereavement on average 13 months previously, Frantz et al. (1996) found that 77% of the sample reported their religious beliefs as helpful in coping with their grief. Further analysis revealed that approximately 20% reported finding comfort in the belief that their deceased loved ones were in some kind of afterlife and free from suffering; 20% reported a sense of hope or optimism in the belief that they would be reunited with deceased loved ones and that deceased loved ones continued to watch over and support participants; and 23% reported the importance of religious practice elements that included prayer, church service attendance, masses/communion, and funeral-related practices. Faith in God was also mentioned as important here. These practice elements were associated with feelings of comfort, strength, safety, and solace during grieving (Frantz et al. 1996). Interestingly, Frantz

et al. (1996) also found that participants reported members of the clergy as being equally as helpful to coping as therapists, although only approximately 5% of the sample reported these people as helpful.

Further support for the use of religious practice elements in coping comes from the above mentioned study by Clarke et al. (2003) who found that religiousness was not only associated with fewer health problems following bereavement but also with increased coping strategies used including increased use of spiritual/church related activities. However, this study did not identify the spiritual/church related activities that the bereaved used.

Although the findings from these studies, and particularly that of Frantz et al. (1996), provide insight about the content of religious belief and practice that is important to the bereaved, disappointingly these studies provide little explanation about how and why participants find this content helpful. Although conclusions suggest that beliefs such as belief in a God or an afterlife provide comfort or optimism, little or no explanation has been advanced for why practices such as prayer, church services, and communion/mass are beneficial to the bereaved.

4.1.3 Meaning-Making and Meaning Reconstruction

The concept of meaning-making has been discussed in several different ways, however in the context of coping with bereavement it usually refers to a process of developing an explanation or understanding of one's bereavement that brings some level of comfort or acceptance. Indeed, it is widely acknowledged that following a significant loss the bereaved can feel a strong motivation to search for some meaning in their bereavement and may implicitly or explicitly draw on different resources in the process. As is widely recognised, one primary resource that has traditionally been drawn upon in times of difficulty or trauma is religion (Pargament, 1997). Part of religion's appeal is that it can offer explanations that are qualitatively different in nature from explanations provided by science or rationalism. According to Davis and Nolen-Hoeksema (2001) people who are coping with a significant bereavement are often unsatisfied with meaning derived from causal attributions (e.g. the bereavement was because of a disease or because of a traffic accident) but actively try to understand their loss and find meaning at a deeper level or in a more poignant way.

Research by Golsworthy and Coyle (1999) has identified that the bereaved do indeed use their religious beliefs to search for and create meaning related to multiple aspects of their bereavement. In their study of bereaved older adults, mean age 67.2 years, who had lost a

spouse, these researchers found that religious beliefs were involved in explanations for why the loss occurred, in attributions of responsibility for the loss to God, in continuing a perceived relationship with the deceased spouse, and in identifying reasons to continue with their life. Interestingly, however, this study reported few details about the role of religious practice in meaning-making and coping more generally.

One of the most recent and explanatory theories of coping with bereavement that places heavy emphasis on meaning-making processes is meaning reconstruction (Neimeyer, 2001, 2006), and specifically the constructivist version forwarding by Gillies and Neimeyer (2006, see section 1.14). This theory proposes that central to grieving are three unique and distinct meaning-making processes: sense making, benefit finding, and identity change. According to this theory following a significant bereavement, in the process of coping and adjustment, people will often attempt to make sense of their loss, search for some kind of benefit from it, and experience a change in identity. Although the empirical evidence for this theory as a whole is still limited the core components of the theory have received individual support and importantly that they hold the potential to be influenced by religious/spiritual sources (Gillies & Neimeyer, 2006; Neimeyer, Baldwin, & Gillies, 2006). These processes are briefly described below.

4.1.4 Sense Making, Benefit Finding, and Identity Change

Sense making can be succinctly described as a process of trying to comprehend and find reason in a traumatic event such as a significant bereavement. As highlighted by Gillies and Neimeyer (2006), the losses that may be most difficult to cope with are those from which little or no sense can be made as these are likely to leave the bereaved feeling vulnerable in a world that appears random and unpredictable. As part of the sense making process the bereaved may engage in questioning of aspects related to the loss or in attributing reasons for the cause of the bereavement (Gillies & Neimeyer, 2006). Sense making may contribute toward the bereaved being able to assimilate the loss within pre-existing meaning structures used to understand the world, or alternatively in the modification or restructuring of pre-existing meaning structures in order to accommodate the loss (Gillies & Neimeyer, 2006).

Although sounding somewhat paradoxical, benefit finding refers to the process of identifying something positive in one's experience of bereavement (Davis & Nolen-Hoeksema, 2001). Benefit finding may be helpful to the bereaved by providing a form of psychological compensation that may ameliorate some of the negative consequences of the bereavement

experience, or by providing a distraction from focusing only on the negative aspects of the loss (Davis & Nolen-Hoeksema, 2001). In research that has examined the influence of both sense making and benefit finding in bereavement, although both were related to bereavement adjustment these processes were found to be unrelated to each other. Furthermore, while sense making was found to be related to adjustment earlier in grief, benefit finding was found to become more important with increasing time (Davis, Nolen-Hoeksema, & Larson, 1998).

Finally, identity change refers to the process whereby following a significant bereavement, in addition to experiencing negative changes, some people also report experiencing positive changes in their sense of self or identity. According to meaning reconstruction theory, following a significant loss the bereaved engage in rebuilding their fundamental assumptions about the world and in the process inevitably reconstruct their sense of self, integrating the loss into their new identity and in editing their new self-narrative (Gillies & Neimeyer, 2006). Through this process of accommodating the loss new strengths or personal growth can be experienced and new sources of meaning and purpose may be identified (Gillies & Neimeyer, 2006).

4.1.5 The Present Study

The aim of the present study was to identify the content of Christian belief and practice used by older adults in their experience of spousal bereavement, and to investigate how religious content translates or is converted into specific ways of coping. As part of this process the study also aimed to identify whether religious belief and practice are used in meaning reconstruction (i.e. sense making, benefit finding, and identity change).

Based on the review of the religion and bereavement literature (see section 2.5) a qualitative design was selected as it was thought that this approach would be best suited to identifying the content of religious belief and religious practice most often drawn upon or used in coping with bereavement, and to identify content that may not be well represented within the existing knowledge base. At present there is a relative sparseness of qualitative research and it has been suggested that qualitative research is needed in part to facilitate interpretation of the quantitative findings (Fry, 2001; Walsh et al. 2002). In addition, it can also be discerned from the bereavement and meaning-making literature that more qualitative research is needed to identify the religious content involved in post-bereavement related meaning-making and meaning reconstruction.

4.2 Method

4.2.1 Participants and Sample

The study used a theoretical (purposive) sample of British older adults who had a strong Christian religious belief and membership, and who had experienced bereavement from a spouse. There were 26 participants used in the study, the mean age of participants was 76.4 years, (SD) = 6.6 years, with an age range of 60 to 86 years. There were 19 females and 7 males, 25 participants were Caucasian, and one was Indian.

4.2.1.1 Sample Bereavement Characteristics

All participants had been married to their deceased spouse. Table 4 shows that participants had been married to their spouse for on average 40 years prior to bereavement, were on average in their mid-to-late sixties when bereaved, and had on average experienced their bereavement within the last seven to ten years.

Table 4.

Means, standard deviations, and age ranges for number of years married, participant age at time of bereavement, and time since bereavement.

	M	SD	Range
Length of time married	40.0* (43) years	11.7 years	7 - 56 years
Age at time of bereavement	66.8* (70) years	10.7 years	39 – 80 years
Time since bereavement	9.5* (6.5) years	10.8 years	10 months - 45 years

* These figures include one extreme outlier, an 84 year old widow who lost her husband 45 years ago when aged 39 years, thus affecting the mean. To compensate for this, the median, which may be a more accurate measure of central tendency, appears along side the mean in brackets ( ).

Table 5 details that the sample experienced both sudden and expected bereavements, although anticipated bereavements preceded by a chronic illness were more than twice as common. Table 5 also shows that the sample varied in the causes of death of participants' spouses. The most common cause of death was heart or lung conditions, with the second most common cause being a type of cancer. The sample also included participants who had lost their

spouse through stroke and from a form of dementia. Other causes of death included traffic accidents, leukaemia, and suicide.

Table 5.

Number of participants and percentage of sample for level of bereavement forewarning and causes of bereavement.

	N	%
FOREWARNING		
Expected bereavement (chronic illness, months/years)	19	73%
Sudden bereavement (no forewarning or hours/days)	7	27%
CAUSES		
Heart or lung condition (e.g. pneumonia, aneurism)	9	34%
Cancer (of either lungs, kidneys, liver, ovaries)	7	27%
Cerebral tumour or disease (e.g. stroke or brain tumour)	4	15%
Degenerative neurological disease (e.g. Alzheimer's disease)	2	8%
Traffic Accident	2	8%
Leukaemia	1	4%
Suicide	1	4%

4.2.1.2 Sample Religious Characteristics

All 26 participants stated having a Christian belief and were members of a Christian denomination. Fifteen (58%) participants stated Church of England (Anglican) membership, and 11 (42%) stated Roman Catholic membership. Twenty-two (84.6%) participants shared the same Christian belief and denominational membership as their deceased spouse, and 4 (15.4%) shared the same Christian belief but belonged to a different Christian denomination as their spouse.

4.2.1.3 Eligibility Criteria and Recruitment

Participant eligibility and recruitment was similar to that used by Golsworthy and Coyle (1999) in bereavement research with religious older adults. Eligibility criteria included: 1) being over 55 years of age; 2) having experienced bereavement from a spouse; and 3) Christian religious belief being of some importance and regular church attendance (preferably at least once a week). In addition, from the participants who volunteered to participate, a telephone conversation was used to establish whether participants felt their religious belief had or was playing a helpful role in their coping process. All participants who contacted the researcher were subsequently interviewed.

The majority of participants were recruited through adverts in church newsletters and notice boards, and through word of mouth via church members. Participants were also recruited via referrals from two Church Ministers one Anglican and one Catholic who were asked to pass on details of the study to people who met the study's eligibility criteria. Overall, participants were drawn from across three counties in the south of England and lived in both urban and rural areas in and on the outskirts of four large cities.

4.2.1.4 Sample Socio-demographic Characteristics

Of the 26 participants, 20 (77%) reported no physical health problems and 6 (23%) reported minor health problems which included arthritis, stomach and liver ailments, osteoporosis, and hip and mobility problems. Of these six participants, all were receiving medical treatment. Nearly all of the participants reported no mental health problems, only one participant reported experiencing depression and was receiving a course of anti-depressants.

The participants had varying educational backgrounds, for the majority of participants, 12 (46%), the highest level of academic attainment was a secondary school education, while 8 (31%) had received some further education, and 6 (23%) had received a university education. Twenty-three (88%) participants lived alone, while two participants lived with one or more adult children, and only one participant, a male, had remarried following bereavement. All but one of the participants had retired from permanent employment. The only participant who was still in full time employment was the youngest participant in the sample. The participants reported varying socioeconomic statuses; however none of the participants reported any significant financial worries.

4.2.2 Design

A mixed methods design was used which predominantly involved qualitative in-depth semi-structured interviews to investigate the religious cognition and practice used in coping and meaning reconstruction. Interpretative Phenomenological Analysis (IPA) was used to analyse interview transcripts (see section 4.2.5). The study also included two questionnaires (see section 4.2.3).

A semi-structured interview approach was chosen because a large body of previous research with bereaved participants (Stroebe, Stroebe, & Schut, 2003), and with older adults (MacKinlay, 2001a, 2001b, 2005), and religious members (Pargament, 1997) had shown interviews to be a successful method of capturing the personal experiences and meaning-making processes of these groups. Furthermore, semi-structured interviews are considered the optimal method of data collection for IPA of subjective experience and cognition (Brocki & Wearden, 2006; Smith & Osborn, 2003; see section 4.2.5.1 for justification of IPA).

The advantage of using semi-structured interviews is that they allowed participants to express their experiences in a free and natural way not restricted by researcher fixed responses as in the case of structured interviews or questionnaires. In addition, semi-structured interviews allowed participants to talk in-depth and at length about their experience in a way not inhibited or persuaded by the presence of several other people, and without the influences of group dynamics (e.g. leadership, conformity) as can be the case with focus groups (Smith & Osborn, 2003; Wilkinson, Joffe, & Yardley, 2004).

4.2.3 Materials and Apparatus

An informed consent form (see Appendix I) and debriefing form (see Appendix J) were provided to all participants. (It should be noted that during debriefing it was also verbally articulated where appropriate that if participants wished to talk about their bereavement with a trained counsellor then the contact details of a counsellor experienced in bereavement with older adults could be supplied. The contact details for "Cruse" a national bereavement organisation was also at hand in cases where participants wanted to talk to a professional about any difficulties they may have been experiencing with their bereavement).

4.2.3.1 Socio-demographic Measure

A socio-demographic questionnaire (see Appendix K) was composed to measure twelve socio-demographic variables considered to be most influential in confounding research on

health and religion, these variables included; age, gender, health status, mental health, health behaviours, education, employment status, perception of one's financial situation, geographic region, marital status, social support, and ethnicity (Berry, 2005). The socio-demographic questionnaire had a free response format and was employed to examine any salient differences between participants that could potentially confound the content derived from interviews. Broad socio-demographic information also helped to contextualise findings.

4.2.3.2 Religious and Spiritual Belief

The Beliefs and Values Scale by King et al. (2006; see Appendix L) was used to measure strength of spiritual and religious belief. The scale was employed to provide confirmation that participants had a strong religious/spiritual belief. The scale is composed of 20 items, ten items explicitly measuring spirituality (e.g. I feel most at one with the world when surrounded by nature), and ten items measuring concepts related to traditional Christianity (e.g. I believe in a personal God). The scale has a five-point Likert-type response format (strongly agree = 4 to strongly disagree = 0) and yields a score ranging from 0 to 80, with a higher score indicating stronger spiritual/religious belief. The scale has excellent internal consistency reliability with a Cronbach's alpha of 0.94, and good criterion validity with a correlation coefficient of 0.70 with total score on the Intrinsic Religious Motivation Scale (Hoge, 1972). The Beliefs and Values scale is also considered to have acceptable test-retest reliability over a two-week period.

4.2.3.3 Interview Schedule

The different domains of interest on the interview schedule were developed following consultation with a number of individuals specialising in either bereavement or religion, for example a counsellor with bereavement experience; a clinical psychologist specialising in bereavement research; serving Anglican, Catholic, and Orthodox Church ministers; and finally with members of Catholic, Anglican, and Orthodox Churches. In addition, the researcher attended religious services to gain a deeper understanding of modern and traditional Christian belief and practice (see Appendix M, Reflexivity section, for researcher reflections on the factors that contributed toward shaping the research).

The interview schedule (see Appendix N) provided a loose framework about areas of interest to be covered during interviews, and was designed to encourage participants to describe their own experiences in their own words with a minimum of direction from the interviewer

(Brocki & Wearden, 2006; Smith & Osborn, 2003). The schedule contained 15 specific questions, and was designed to investigate in-depth three broad areas of experience unique to participants: 1) The role and importance of religious belief and practice in the participant's life; 2) the experience and circumstances of bereavement and coping; and 3) the role/use of religious belief and practice in meaning reconstruction and coping.

More specifically, questions one to three focused on establishing an understanding of the participant's religious belief system, practice, denomination, and the importance and meaning of religion to the participant. Questions four and five were used to establish details about the circumstances of the bereavement, the deceased, years of marriage, and how the participant coped/is coping. Questions six to eight were used to investigate the role of religious belief and practice in coping, to identify the specific religious content or practice the participant found most helpful or important in coping and why this content and practice was helpful. Questions nine to eleven were used to investigate the role of religious belief and practice on the components of meaning reconstruction (i.e. sense making, benefit finding, identity change), and were adapted from quantitative items used by Neimeyer, Baldwin, and Gillies (2006) to measure meaning reconstruction. The remaining questions, twelve to fifteen, were used to investigate any change in belief or practice following the experience of bereavement; the role of religious belief in continuing bonds; and the role of belief in providing hope/optimism for the future; and offered the participant the chance to summarise the role of their religious belief and practice in their bereavement experience. These latter questions provided the interviewer with the opportunity to follow-up anything that emerged as important during the interview, or identify any omissions or topics that had not been tapped into or covered via earlier questions.

Questions were worded to be as open-ended as possible and to allow the participant to respond at length and with any information felt relevant. Questions were also worded with every attempt made to eliminate leading questions, and the technique of "funnelling" was used where appropriate to move from general to specific questions. Prompts were included on the schedule to highlight important areas of interest associated with a specific question that helped the interviewer not to forget anything that could be potentially important. An example of a prompt was "what does church attendance mean to you?"

Probes were used where appropriate to allow participants to supplement and elaborate on their responses (Smith & Osborn, 2003; Wilkinson et al. 2004). Importantly, probes also allowed the interviewer to follow-up information relevant to specific questions and to broaden the interviewer's own knowledge of a particular area important to the participant's experience

(e.g. in cases of religious practice or religious terminology). Probes were also used to allow the research to move into unanticipated, new, or related areas (e.g. the role of religious belief in caring for a spouse prior to bereavement). An example of a probe was "can you describe that ritual for me?" or "can you tell me how prayer helped you?"

Prior to the main study a pilot study was used to test-run the developing interview schedule. The pilot study included three bereaved older adults, two females and one male, with a mean age of 74.3 years, SD = 5.0 years, an age range of 69 to 79 years, with a mean time since bereavement of 5.7 years, SD = 2.1 years, and a moderate-to-strong Church of England religious belief (Beliefs and Values scale M = 51.3, SD = 8.1). Use of the pilot study allowed for the modification of the order and number of questions on the interview schedule, and for the modification of the delivery and wording of questions. Importantly, the pilot study also allowed the researcher to become familiarised with the procedure. Participants used in the pilot study are not included in the final analysis.

Prior to interviews, the researcher had received interview training, and received practical advice from a counsellor and clinical psychologist about interviewing bereaved older adults. For example, practical advice involved being empathic and sensitive toward participants, being a good listener, trying not to cut in too soon during silences, reducing psychological terminology to a minimum, speaking clearly and repeating questions where necessary, and keeping a box of tissues nearby in case participants needed to cry.

Finally, all participant responses to questions on the semi-structured interview were recorded using a Sony TCM-200DV compact cassette recorder.

4.2.4 Procedure

All participants were interviewed individually and on one occasion in their own home. Due to the sensitive and potentially upsetting nature of bereavement research the interviewer endeavoured from the start of the meeting to make the participant feel as comfortable and relaxed as possible, and remembered to be empathic and "tuned in" to the participant's emotional state and circumstances (Wilkinson et al. 2004). Before beginning the interview, the interviewer gave a brief personal introduction, explained about the background of the study, and gave a brief overview of the questions to be asked and questionnaires to be administered. Once participants were happy with the nature of the study and what would be asked all participants completed an informed consent form agreeing to take part in the study and to be

recorded. Participants were then given the opportunity to ask any questions or express any concerns they had.

It was carefully explained to participants that they could withdraw their consent at any time during the interview and that if they became too upset the interview could be paused at any moment. It was also explained that information provided would be kept confidential and accessible only by the interviewer, that to preserve participant anonymity personal details would be changed or removed from interview transcripts and published extracts, and that tapes would be deleted following transcription and analysis. Before the interview began, the interviewer double checked that the participant was happy to continue.

The overall study procedure was grouped into three broad stages; first, completion of the socio-demographic questionnaire and Beliefs and Values scale; second, engagement in the questions on the semi-structured interview schedule; and finally, the mood repair component.

4.2.4.1 Questionnaires

The items on the socio-demographic questionnaire were administered first followed by items on the Beliefs and Values scale. The administering of these scales first provided a gentle introduction to the study and allowed the opportunity for the participant and interviewer to build up a rapport before moving on to questions on the interview schedule of a more sensitive nature.

4.2.4.2 Semi-Structured Interview

The questions on the semi-structured interview schedule began with the participant stating their age for the tape and providing a brief description of their background, interests, hobbies, and their family (e.g. children, grandchildren). These questions served as a way of easing the participant in to talking openly and naturally before moving on to more demanding and sensitive questions and also allowed the participant to get used to the tape recorder. These questions also served the function of furthering the relaxed and friendly atmosphere and maintaining the rapport between interviewer and participant. In addition, responses to these questions would later provide a context in which to further understand the role and importance of religion in the participant's life and the impact of their bereavement.

Participants were then asked questions about their religious belief and practice, the circumstances of their bereavement, how they coped, and the use of their religious belief in coping and meaning reconstruction. It should be noted that the interview schedule was used

flexibly and adapted to fit how the individual participant described their bereavement circumstances, coping experience, and the specific religious beliefs and practices they articulated as helpful. Furthermore, although questions on the schedule were kept to a pre-defined order, on some occasions the order was changed when participants spontaneously mentioned information relevant to later questions. On these occasions the interviewer followed this information up as naturally as possible as it was mentioned.

Towards the end of each interview the interviewer would summarise participant information in the participant's own words to check that the interviewer had understood and been sensitive to what the participant had said. At the end of each interview all participants were given the opportunity to clarify any information they had given throughout the interview, or add anything they felt was important for the interviewer to know about their experience and had not already been mentioned.

4.2.4.3 Mood Repair

Following the semi-structured interview questions the interviewer began the mood repair component, a process recommended by clinicians for research of an emotional or sensitive nature. The mood repair component was adapted to fit the tone of the study and age group of participants and therefore took the form of a general conversation with the participant. The mood repair component allowed the interviewer to make sure that the participant was not left in a distressed state by the interview and was left in the same emotional and psychological state that the interviewer encountered the participant. The mood repair conversation involved a general chat with the participant and lasted for approximately 10 to 20 minutes. The participant was free to talk about any topics of interest to them, and usually revolved around events at their local church, current affairs, their grandchildren, or their hobbies. This conversation also allowed the participant to ask any questions or to seek any information about any areas discussed during the interview.

Following the completion of the mood repair conversation the participant was verbally debriefed, offered a copy of the debriefing statement and thanked for their participation. Overall, each interview, including completion of the two questionnaires and the mood repair component, lasted for approximately 2 to 3 hours.

4.2.5 Analysis

All interviews were transcribed verbatim and in as great a detail as possible noting pauses in speech, word emphasis, repetition, interruptions in speech, turn taking, and expression of emotion (e.g. laughing, crying, sighing, etc.). Also, where appropriate participant non-verbal behaviour was recorded, cultural references, and references to Biblical passages quoted (e.g. *St. John, ch.11, v.25-26*). To preserve participant confidentiality and anonymity, identifying characteristics (e.g. names of people, places) and identifying passages (e.g. details about spouse, family, institutions), were changed or removed from transcripts.

4.2.5.1 Rationale

Interpretative Phenomenological Analysis was used to analyse transcripts. IPA was selected because it is a method of exploring in-depth and in detail the psychological processes through which participants come to perceive, experience, and make sense of some aspect of their personal world. The objective of IPA is to engage in analysis of a participant's personal account of a phenomenon and to take as close as possible an "insider's perspective" of the participant's psychological world in order to develop an empathic understanding of how the participant experiences a particular phenomenon. The aim of IPA is then to be able to produce insight or knowledge about the participant's thinking, beliefs, and experiences in relation to this phenomenon (Conrad, 1987; Smith & Osborn, 2003; Willig, 2001).

Developed by Smith (1996) and colleagues (e.g. Reid, Flowers, & Larkin, 2005; Smith & Osborn, 2003; Smith, Flowers, & Osborn, 1997; Smith, Jarman, & Osborn, 1999), IPA has become widely used in health psychology, and is increasingly being used in clinical psychology and social psychology (Brocki & Wearden, 2006; Shaw, 2001; Smith, 2004). IPA is derived from and influenced by several different theoretical and philosophical traditions that have a long and established history in social scientific research. The influence of phenomenology, symbolic interactionism, and hermeneutics, shape and inform the epistemological and ontological approach of IPA.

The method is considered phenomenological because it is interested in a participant's subjective account of a phenomenon, involving perceptions, views, beliefs, feelings, and experiences, rather than an objective account or facts about a phenomenon (Smith & Osborn, 2003). Similarly, IPA is influenced by symbolic interactionism by recognising that the experiences people have of some event in their personal world can be shaped and modified by the meanings and significance they attribute or attach to this event. Therefore, what can appear

an "objective" event, such as bereavement, can be experienced in varying ways depending on the subjective and social meanings attributed to the event. Thus, the IPA approach acknowledges that a participant's personal world and the meanings they attribute to experiences cannot be accessed directly but have to be actively interpreted by the researcher (Smith et al. 1997). However, rather than seeing the thinking and assumptions brought to the interpretative process by the researcher as types of bias that should be controlled, IPA sees the perspective of the researcher as necessary and essential for understanding and appreciating another's experience (Willig, 2001). Therefore, in essence, the method of IPA is proposed to denote a dual hermeneutic process at work, "the participants are trying to make sense of their world; [and] the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p.51).

IPA was selected over other language-orientated qualitative methods for several reasons but primarily because IPA is concerned with cognition and the content of cognition and in how that content can be accessed. For example, unlike discourse analysis that is sceptical about language representing underling cognition, IPA sees a link between a person's account of an experience and their thinking (Smith et al. 1999). IPA proposes that through a systematic and detailed analytic examination of a participant's account it is possible to understand and make sense of the participant's thinking (Smith et al. 1999). The IPA approach through its emphasis on interpretation allows the researcher the freedom to be reflexive and ask critical questions of a participant's account, through which unique insights can be reached. For example, in analysis the researcher may identify something that participants themselves are unaware of or identify something that participants are trying to hide or mask (Smith & Osborn, 2003).

IPA also differs from grounded theory in that although interested in making theoretical generalisations about how people make sense of a particular experience, the process of analysis does not attempt to verify an inductively developed theory. In addition, while sharing a commitment to identifying themes and patterns in language with thematic analysis, the philosophical framework of IPA and its emphasis on active interpretation during the process of analysis can facilitate a deeper level of understanding about experience and thinking than thematic analysis.

4.2.5.2 The Process of Analysis

The process of analysis applied to interview transcripts was guided by the procedures for conducting IPA detailed by Smith and Osborn (2003), Smith, Jarman, and Osborn (1999),

and Willig (2001). The process of analysis takes an idiographic approach and essentially treats the sample as a set of individual case studies focused around a similar shared phenomenon (Smith, 2004; Smith & Osborn, 2003). In broad terms, the process of analysis began with a detailed case-by-case examination of participant transcripts, inductively foregrounding participant thoughts and experiences related to religion, bereavement, and coping, and gradually moved toward an integration of similarities and differences in thinking and experiences shared by participants.

At a more specific level, the first stage of analysis began with each participant's transcript being read and re-read several times in order for the researcher to become immersed in the data and to become familiarised with the transcript accounts. The next stage involved returning to the first transcript and openly annotating all the text line-by-line and/or by sentence/paragraph and noting what the participant was saying, language used (e.g. metaphor, simile), associations, contradictions, and points of general and specific interest. Notation of transcripts at this stage was influenced by both manifest and latent coding techniques utilised in thematic analysis. Manifest coding was used to note material that was explicit and directly observable, while latent coding was used to note material that was inferred or implicitly present (Joffe & Yardley, 2004). Taken together, these coding techniques helped facilitate access to participant meaning-making processes and underlying thoughts and assumptions about their experience.

Once the transcript had been annotated, the next stage of analysis involved a systematic re-reading of the same transcript and this time transforming initial notations and codes into concise labels representing emergent themes. The labels used were applied to segments of text (or line-by-line in instances where more than one theme was present) and were at a higher level of conceptualisation than initial notation. Labels often took the form of psychological terminology and aimed to capture and characterise the essence of the experience represented in the text. In accordance with the flexible approach of IPA, emergent themes were identified and established based both on their prevalence and frequency throughout the transcript and on their salience in providing insight about the phenomenon under investigation (Smith & Osborn, 2003, Smith et al. 1999).

Still working with the first transcript, the next stage of analysis aimed to introduce some structure on the accumulated themes and involved clustering emergent themes based on their similarities and differences, and on their relationship to other themes. The clustered themes were then given an overall label that captured the essence and quality of the participant's

experience. These overall labels represented salient themes for that individual and were then checked to make sure they were grounded in the participant's account. Once emergent themes for the first transcript were established this was used to guide and inform analysis of the next transcript which started with the initial stage of openly annotating the text.

Once each transcript had been notated and emergent themes had been identified and established, the overall themes for the entire data corpus (i.e. the entire set of transcripts) were clustered and organised under an inclusive set of superordinate labels. These superordinate labels were based either on words or phrases that best summed up or described the participants' experiences or based on *in vivo* descriptions used by the participants themselves to describe their experience. This inclusive set of superordinate themes represented the shared experiences of participants. These themes were then checked through re-reading of transcripts to ensure that they were grounded in participant accounts. Analysis and development of inclusive superordinate themes continued until all participant overall themes had been accommodated or accounted for within inclusive superordinate themes.

Although the process of analysis is presented in a linear and discrete fashion, in reality analysis was an iterative and cyclical process involving repeatedly moving back and forth within and between transcripts and checking and examining similarities and the reoccurrence of themes. In addition, the interpretative act of making sense of the meanings in participant accounts was involved at every stage of analysis and even during the interview process itself and during transcription of interviews. Once enough data had been collected to develop an insightful and comprehensive account of the religious content and practice used in coping and meaning reconstruction, and once newly collected data was considered to be adding relatively little new insight, saturation was judged to have been reached and further recruitment was felt unnecessary (Chamberlain, Camic, & Yardley, 2004).

4.3 Results and Analysis

4.3.1 Beliefs and Values Scale

Participants from both Anglican and Catholic denominations scored highly on the beliefs and values scale. Analysis of scores revealed that there was no significant difference in strength of religious and spiritual belief ($t = 0.41$, $df = 24$, $p = 0.68$) between participants with a Roman Catholic belief and membership (M = 65.3, SD = 5.6) and participants with a Church of England belief and membership (M = 64.0, SD = 8.2). Thus, these findings reduced the likelihood of a bias in content articulated based on strength of religious belief inherent to one or other denominational group.

4.3.2 Interpretative Phenomenological Analysis

The qualitative data from participants provided a wealth of information about a wide range of issues, including experiences of bereavement and grief; the nature of religion, spirituality, and faith; and challenges faced by ageing and growing older alone. However, during the process of analysis data related to religious content and practice and the role played by content and practice in coping and meaning-making are foregrounded and discussed in detail. During analysis where appropriate verbal extracts are given to illustrate, elucidate, and support interpretations. The following notation (…) represents a pause in speech, while (. . .) represents omissions from original text; where necessary words in square brackets [] provide clarification about the subject or activity the participant is discussing. Following a quotation the name of the participant is supplied and line numbers from where in the interview transcript the quotation is taken from, for example (Betty, L.105-106). Interpretative Phenomenological Analysis revealed four main themes: Benevolent religious cognition; Biblical assurances; religious ritual; and spiritual capital and growth.

4.3.3 Benevolent Religious Cognition

The first major theme to emerge was benevolent religious cognition. This theme represents the principal religious cognition and beliefs that were expressed as most salient to coping and meaning-making, and that participants described as beneficial, comforting, or helpful. The cognition that was central to this theme revolved around three Christian-related beliefs: belief in God, belief in life after death, and belief in a life after death reunion with their spouse. These important cognitive beliefs re-occurred across all participants and were central to interpretations and re-interpretations of the bereavement and grief experience. These

religious beliefs are grouped under the label "benevolent" because they all share in common an essentially positive and optimistic interpretation of their loss as less negative. These beliefs can also be viewed as the antithesis of the negative thoughts and feelings aroused by a significant bereavement experience. The use of the word "benevolent" is also chosen because it fits with the terminology used by Janoff-Bulman (1992) in her theory of "assumptive worlds" and reflects how specific yet diverse religious cognition can counteract or ameliorate the malevolent realisation and consequences caused by bereavement that can shatter fundamental assumptions about the self and the world.

4.3.3.1 Belief in God

Consistent with Christian doctrine, at the centre of participants' benevolent religious cognition was belief in God. Every participant believed in God, and described God as a transcendent or sacred person or figure (although not physically tangible via the primary senses), or as a presence or spirit, that was omnipresent. When referring to or talking about God, all participants used interchangeably where appropriate the pro-nouns "He" or "Him", or "the Almighty" or "Lord". For the majority of participants, the name "Jesus" was used to refer to God in His physical, Earthly form as described in Biblical sources. Throughout interviews there was an implicit belief that the Holy Spirit was the power, force, or presence of God that was present in the world and through which intercessions could occur. In describing the essence or nature of God, every participant used positive and virtuous terms such as "compassionate", "merciful", "forgiving", "patient", and "generous". However, there was an overarching emphasis in describing God as caring.

> In my Catholic belief God cares for you through life and through death (Sandra, L.433).

In their efforts to cope with bereavement from their spouse, all of the participants described God or their religious belief as providing an inner sense of "strength" to cope, and felt that without their Christian belief they would not have been able to cope as well.

> God gives you the strength to go on, it's through His strength that you go on really, I think without my Christian faith it would have been much more difficult (Elizabeth, L.382-384).

On closer inspection this sense of "inner strength" to cope could be likened to a form of determination or motivation, and could be inspired by belief in God. In addition, most

participants felt that during their bereavement and grief, God was in some way supporting them or, from the participants' perspective, was "on your side".

> His love is unconditional umm…and so He is always there, He is a God who is infinitely merciful. . .He's there to count us in not to count us out, so you know He's infinitely merciful and umm and He's just recklessly generous umm in the grace that He gives us to, in the form of strength to cope (George, L.92-98).

Furthermore, during their coping efforts, most participants described feeling that God was somehow close or near to them, and that this sense of "closeness" was comforting during grief by preventing participants from feeling as if they were alone or isolated.

> Well I think it's the comfort you get from knowing that there's someone there with you close by, say God or Jesus, whichever but…I don't think you're on your own, you might feel as if you are but you're not, He is close to you (Pat, L.694-696).

In addition, nearly every participant described feeling a sense of protection or providence directly from God, while for a smaller number there was also the additional belief that their deceased spouse was in some way able to protect or watch over them.

> I do believe there is a God and I believe that my husband is with Him, and I believe that they are both looking after me (Sarah, L.1254-1255).

4.3.3.2 Belief in Life After Death

The second belief essential to benevolent religious cognition was belief in an afterlife of some description. All of the participants believed in an afterlife and referred to it as "heaven", "paradise" or "eternal life". In attempting to describe the afterlife all participants remarked about having great difficulty in trying to visualise what it would be like. However, most descriptions included that it would be free of sin, and most noticeably that it would be free of suffering, perhaps reflecting the negative disposition felt toward suffering that many had experienced in witnessing their spouse's illness and death or through their own grief. For the majority of participants, both Anglican and Catholic, their spouse had ascended to this afterlife destination immediately following death.

> I have no doubt my husband went straight to heaven, no purgatory, no waiting rooms, and he is there now in the presence of God and the company of his parents and family (Julia, L.434-437).

For most participants the belief that their spouse had moved on to an afterlife helped ameliorate some of the negative impact of grief.

> Grief is blunted because there is the knowledge that your beloved has gone into something which is better and greater (Philip, L.241-243).

Moreover, a number of participants remarked that knowing the generally "good" life led by their spouse helped them to believe that their partner was in heaven, which in turn helped them to cope. Interestingly, the majority of participants, including those with a Catholic belief, were uncertain about the Roman Catholic afterlife concept of *purgatory*, the belief in a state where the dead may be cleansed of their sins before entering heaven (Gill, 1997). Participant uncertainty about this belief was principally based on the fact that it did not fit with their belief in a merciful God. As Sandra, a 75 year old cradle Catholic described:

> I've always believed in a loving God, well hoped in a loving God, and I've always prayed to a loving God which is why things like purgatory just don't fit in with that you know (L.56-58).

For many of the participants, both Catholics and Anglicans, the experience of their loss had made them come to see purgatory as an aspect of the living world.

> My belief about purgatory is that we live in purgatory now and…and how we deal with it…is, is the way to Christ, to heaven if you like (Clare, L.865-867).

For those participants, mainly Catholics, who did believe in purgatory, it was described as a "cleansing" or "purification" process, and nearly all the participants that believed in purgatory also believed that their spouse had now left purgatory and entered heaven. Perhaps unsurprisingly no participants described their spouse as suffering as a result of an unfavourable afterlife judgement on their life, or were residing in hell. Indeed many questioned the notion of a final judgement or hell for similar reasons as stated for purgatory, namely that they did not fit with ideas of a loving God. Interestingly, many participants remarked about their belief that hell and purgatory were not so much places that people are sent to but states of being separated from the love of God. Revealingly, there was a sense that what seemed to underlie this belief was the separation from love experienced as a result of bereavement from their spouse. In sum, knowing where their spouse was located (i.e. in heaven) and knowing that their spouse was safe and not suffering appeared important beliefs to many in coping.

4.3.3.3 Belief in a Life After Death Reunion with Spouse

The third belief essential to benevolent religious cognition was the belief in an afterlife reunion with the deceased spouse whether immediately or following the resurrection. Every participant believed that they would in some way be reunited with their spouse in an afterlife and this belief was often described as producing indicators of psychological well-being, such as feelings of hope, optimism, and happiness.

> That life doesn't end here, that we hope we will be reunited with our loved ones, that Christ has promised us the resurrection for all of us who have tried to follow His rules and laws, His way of life, and that while we will feel this physical heart ache, heart break and so on umm…but one day we will be together, and…you know then we will experience once again the joy and the hope we had, that thought gives me great happiness (Anita, L.673-678).

Furthermore, for the majority of participants the belief in an afterlife reunion was described as being central to all coping efforts.

> That was it really…53 years of happy marriage and the prospects of eternity in each others company, that was the key to it all you know, that gives me great hope and optimism (Timothy, L.432-434).

4.3.3.4 Benefit Finding

With regard to benefit finding, most participants were able to identify non-religious ways in which they had found some benefit in their loss (e.g. having had time to prepare; having fond memories of a long happy marriage), but also the majority of participants described their religious beliefs in various ways as helpful to finding some benefit in their loss. For the majority of participants the most common benefits found involved the belief that their spouse was no longer in pain, was no longer suffering, and was in a "better place", which offered some solace.

> No pain, umm…no problems, I think just no pain really and being with God you know, at peace with God, this is what I think we really believe, they are at peace you know whatever they've suffered, and that's the comforting thing, I think to know there's no pain and there's peace for them (Elizabeth, L.1164-1167).

For several participants who were married to a spouse who was equally dedicated to Christianity, they were able to find benefit in the belief that their spouse had achieved their spiritual goal of ascending to or entering into heaven. Timothy, an 81 year old lifelong

Catholic who recently lost his wife after 53 years of marriage described the immediate moments following his bereavement.

> I can remember sitting in the restaurant of the hospital when we had the news, well we'd seen her die…and the children were deeply distressed and I said 'well look…this isn't the end, this isn't the end of the matter, her soul has now gone to her maker and umm…she has, I'm quite sure umm…now attained what she was after, to get to heaven', and so I'm sad but I'm pleased for her…I accept the fact that umm…she's no longer with us but I am very optimistic that we will meet again (L.264-270).

Similarly, a number of participants were able to find benefit through interpreting the death as a celebration of their spouse moving on to a more heavenly afterlife.

> My intellect tells me that if you believe that death is just a transitional phase in your greater life then there is nothing to be afraid of, there's nothing for me to grieve about (Clare, L.916-918). . .I think you've got to be a believer to celebrate death umm…because if you're a believer it is a cause of celebration because you are moving onto that exotic plane, to that next stage in your life where you've been through the purgatory of life and you've now moved onto the heavenly plane (Clare, L.1197-1201).

However, as pointed out by Terry, a 71 year old lifelong Anglican who recently lost his wife after almost 44 years of marriage, although there is some benefit or consolation in believing that his wife is no longer suffering and is in heaven, there is still the physical absence and emotional anguish of the loss to cope with which is the difficult part. Terry's sentiments were echoed in the words of many participants.

> I am at peace in my mind that my wife has passed and that her spirit has gone to heaven, that I accept completely and I don't have any problem with that, what I find I have to try and deal with is the here and now, that's, that's the situation, and therefore when I remember my wife, or when I think about my wife, or when I get melancholy...or whatever word you want to use, it is thinking of her before she passed away and perhaps the pain that she suffered, that's, that's what I find, but I take comfort in the fact that I know that she's alright now, she's alright now (L.415-422).

Interestingly, a small number of participants described having "visions" or vivid interactive perceptual experiences with their spouse within a month or so after their bereavement, and nearly all of these participants were able to use these experiences to derive some benefit from their loss. As Linda, a 69 year old lifelong Anglican who lost her husband after 28 years of marriage describes; the experience of seeing her husband after his death provided confirmation for her that there must be an afterlife.

> It does give you a reassurance of the fact of there being an afterlife but I still cannot visualise what it would be like. . .it was reassuring in the fact that he was okay and that there was something afterwards yes. . .It helped me to cope seeing Steven, seeing he was alright . . .but yes I mean how could I see him if there wasn't anything after death, but it is more of a spiritual than a physical thing (L.505-566).

4.3.3.5 Sense Making

With regard to sense making, one of the most frequently mentioned ways participants described their religious beliefs being involved in making sense of their loss was in the belief that their loss was part of a "plan" known to God, or that there was a "God sent reason" or "purpose" for their loss. However, this reason or purpose may not always be clear to the individual at the time of bereavement, but with hindsight or post-bereavement reappraisals this reason could be understood in terms of the survivor's ongoing life.

> I think one of the most important things any bereaved person can hang on to is the fact that there is a reason and it's the time that God called that person and you know you have to accept that and, and understand it…and when you look back you can see it happened for a purpose…I mean I wouldn't be living in this country or be a member at this church if he hadn't died (Fiona, L.535-540).

In addition, a number of participants articulated in different ways that they felt their religious beliefs provided a framework in which to make sense and accept the inevitability of death, including the death of their spouse.

> I accept that within my faith you know that there comes a time for all of us when we have to pass on, including my wife, so that, the fact that it has happened doesn't shake my belief, it doesn't change my belief at all (Terry, L.723-726).

Furthermore, for a number of participants, the belief that the bereavement was part of God's plan and that the loss was not a random event was expressed as reducing feelings of anger about the loss. Indeed, this sense of attributing or deferring responsibility to what is perceived as a good and caring God who has control over events seemed to facilitate acceptance.

> I believe you are guided throughout your life and whatever happens to you it is for a purpose, and this does help in bereavement, it perhaps prevents some of the feelings that some have in bereavement it perhaps prevents any feelings of anger…which is very much a part of it for many people, 'why has this happened to me?'. . .No, no I can honestly say I didn't feel any anger, I accepted it as part of God's plan (Elizabeth, L.327-335).

One of the most important ways that Christian belief helped participants understand or make sense of their loss was in the implicit and for some not entirely conscious belief that their suffering following bereavement was ultimately linked with future compensation. This link was metaphorically represented in Christian language through the crucifixion or cross representing bereavement-related suffering, and the resurrection representing the ultimate reward of afterlife reunion with their spouse. Although this belief was central to and seemed to underlie much of participants' thinking, it is more explicitly illustrated by George using Christian language to make sense of his feelings of grief, loss, and dejection following his bereavement, and his hope of an eventual passage to reunion.

> The Lord doesn't ask you to be successful, He asks you to be faithful, because you know, if you were a disciple of His at the time of His death, you'd look at Him strung up on the cross, and you'd think 'that's not success, that's failure'…but that's the passage, the cross is always, it's always, it has to be for it to make sense linked with the resurrection (L.289-293).

Similarly, Beth, using different language, this time using good and evil, describes how the suffering experienced in bereavement will ultimately be compensated for through good triumphing over evil.

> It's very much being aware of a presence really and knowing that in spite of all the terrible things that are happening in the world, and bereavement can be included in that, umm there is a presence which is promised good coming out of evil, and so I hang on to that, that belief helps me cope (L.158-162).

In addition, several participants made sense of their bereavement by interpreting their loss and suffering as a trial or test that they had to experience as part of their own spiritual advancement in order to reach heaven.

> The fact that this life is a preparation for ever lasting life, umm that all the events in this life are allowed by God, He permits trials and tribulations, and they are all opportunities to…to conform with His will, I don't, I don't kick against the goat, if He sends me a mentally handicapped child I accept that, I've had children with broken marriages I accept that, I've got un-baptised grandchildren and so on, and I take all this as part of His plan and accept it, and use it and offer it up as something I must suffer to reach eternity, to reach His presence, that they are tests, tests for umm ever-lasting life which I am very optimistic about attaining (Timothy, L.221-228).

Finally, a powerful example of the influence of religious beliefs on sense making and coping comes from George, a 65 year old cradle Catholic who recently lost his wife following

34 years of marriage. George describes how even the religious significance surrounding the date his wife was diagnosed with a terminal brain tumour influenced how he made sense of his loss in a benevolent way that was imbued with positive religious significance and that linked him and his wife's suffering with the suffering experienced by the Virgin Mary in accepting her role as the mother of Jesus.

> She [George's wife] was diagnosed with a brain tumour, a malignant brain tumour on the 15th of September which umm actually set the whole pattern for the way we were going to handle this, because it was the feast of Our Lady of Sorrows, and we both had a strong devotion to Our Lady, to Mary, umm…And so if you like that set the scene of how we were to go about this. . .in other words we were going to have to accept it as part of God's plan for us umm…and that feast of Our Lady of Sorrows is really, it celebrates the umm difficulties that she went through, which obviously she came through afterwards but you know where Simeon tells her that you know a sword will pierce her, her heart [*St. Luke, ch.2, v.21-40*] umm where she has already accepted and has conceived Jesus, and she's accepted that, umm so in other words although she knew not where she was going and how this was going to turn out umm she knew that she was doing the will of God and therefore had implicit trust that He would be there to support her umm providing she kept tuned in to Him, you know through prayer and all sorts of things like that. So, so that if you like set the pattern for us, we didn't know where this was going to end, we knew it was terminal, we didn't know how it was going to shape out but we just, we just knew, that was almost a sign, umm it helped us to say well we've just got to trust…we've just got to accept that this is what the Lord wants from us, it's part of His plan for her and for me (L.42-61).

This description by George also demonstrates that for those religious older adults with a detailed knowledge of the Bible, certain passages can also be used to make sense of loss and support meaning-making processes. The role of Biblical scripture in coping and meaning-making is examined next.

4.3.4 Biblical Assurances

The theme of Biblical assurances represents the use of Biblical passages, quotes, stories, themes, or metaphors in meaning-making and coping with spousal bereavement. The use of the word "assurances" comes from participant descriptions in which selective Biblical scripture that provided assurances about the central tenets of the Christian faith related to death, loss, and suffering (e.g. belief in God, heaven, paradise, crucifixion and subsequent resurrection, death being transient, eternal life) were used to facilitate benevolent, non-fatalistic interpretations about death and bereavement. In this respect Biblical assurances are closely linked to benevolent religious cognition by reaffirming benevolent religious beliefs and supporting

meaning-making processes including sense making and benefit finding. At the same time reading of the Bible has been considered a religious ritual (see section 4.3.5) as it can be engaged in routinely (e.g. daily or weekly).

Although not every participant was presently reading the Bible daily, or had read the Bible immediately following or during their bereavement, nearly every participant owned a copy of the Bible and was able to describe specific Biblical passages, themes, or stories that had helped them in coping. In addition to participants acquiring helpful Biblical content directly from reading the Bible, participants also described acquiring Biblical content from several other sources; for example, through hearing Bible readings or "lessons" at daily or weekly church services, or through monthly Bible reading publications (e.g. the Daily Office; Encounter with God; Faith for Daily Living), and of course from a lifetime of experience of church membership (including Sunday school lessons, and religious ceremonies).

Table 6 shows the books, chapters, and verses of the Old Testament that participants described as helpful to coping and meaning-making, while Table 7 shows the books, chapters, and verses of the New Testament that were articulated as salient to coping. It is noteworthy that although more passages were mentioned from the New Testament than the Old, content from both seemed to be mentioned equally often, although it was remarked that the New Testament, especially the Gospels, was the most important because they detailed the life and events of Jesus (especially the crucifixion and resurrection). In addition, the Psalms from the Old Testament seemed particularly useful in coping.

Broadly speaking, the overall Biblical content mentioned as helpful to coping can be grouped into six subordinate themes or categories, namely: assurances of the key Christian beliefs (e.g. God, resurrection, life after death); light overcoming darkness (also good and evil); strength and determination; deferring responsibility to God; the omnipresence, omniscience, and companionship of God; and inspiration drawn from Biblical characters of suffering (e.g. Jesus, The Virgin Mary, Saint Paul, Job). Although for reasons of space not every Biblical quotation can be examined further in the present results section, it is hoped that the essence of these categories will be captured and elaborated further by participant illustrative quotations.

Table 6.

The books, chapters and verses of the Old Testament of the Bible articulated as helpful in coping with bereavement from spouse*

Book	Chapter	Verse	Truncated Example/Description
Exodus	3	14	I am who I am.
I Kings	17	1-24	Elijah and the ravens…
Job	1	21	The Lord give us, and the Lord take away.
Job	19	25-26	I know my redeemer lives…
Psalm	22	1-31	My God, why hast thou forsaken me?
Psalm	23	1-6	The Lord *is* my shepherd; I shall not want.
Psalm	36	1-12	God is a rightful judge…
Psalm	37	1-40	Do not fret yourself because of evil doers…
Psalm	37	7	Rest in the Lord…fret not…
Psalm	46	1-10	God *is* our refuge and strength…
Psalm	69	1-36	O God, save me from the mire…
Psalm	121	1-8	I will lift up mine eyes unto the hills…
Psalm	130	1-8	Out of the depths have I cried unto thee…
Psalm	131	1-3	Lord, I have given up my pride…
Psalm	139	1-13	O Lord, thou hast searched and known me…
Psalm	139	1-24	When I go down to the depths you are there.
Ecclesiastes	3	1-8	To every thing there is a season…
Isaiah	12	2	I will trust, I will not be afraid…
Isaiah	40	28-31	Hast thou not known? Hast thou not heard…
Isaiah	43	2	I will be with you, when you pass through…
Jeremiah	18	1-6	Parable of the Potter…

* All Biblical citations refer to their location in the authorised King James Version of The Holy Bible.

Table 7.

The books, chapters and verses of the New Testament of the Bible articulated as helpful in coping with bereavement from spouse*

Book	Chapter	Verse	Truncated Example/Description
St. Matthew	5	3-11	Sermon on the Mount.
St. Matthew	7	7-8	Ask, and it shall be given you; seek…
St. Matthew	13	9-16	Blessed are your eyes, for they see…
St. Matthew	17	1-13	The Transfiguration on Mount Hermon.
St. Matthew	20	1-16	Labourers in the Vineyard.
St. Matthew	21	22	Ask in prayer, believing, ye shall receive.
St. Luke	1	26-38	The Annunciation.
St. Luke	1	46	My soul magnifies the Lord…
St. Luke	2	21-40	A sword shall pierce through thy own soul…
St. Luke	23	43	To day shalt thou be with me in paradise.
St. Luke	24	13-35	On the road to Emmaus…
St. John	2	1-11	First miracle at Cana.
St. John	8	12	I am the light of the world…
St. John	11	1-46	The Raising of Lazarus.
St. John	11	25-26	I am the resurrection and the life…
St. John	14	1-4	In my Father's house are many mansions.
St. John	14	27	My peace I leave with you, my peace…
St. John	19	25-27	Jesus placing Mary into the care of John.
St. John	20	25-29	Blessed are they that have not seen…
Romans	8	28	All things work together for good…
I Corinthians	10	12-14	That ye maybe able to overcome temptation.
I Corinthians	13	1-13	Faith, hope, love, of these the greatest is love.
I Corinthians	15	1-58	The Resurrection of the Dead.
II Corinthians	5	8	Absent from the body, present with the Lord.
II Corinthians	12	9	My strength is made perfect in weakness…
Ephesians	6	10-18	Put on the whole armour of God.
Philippians	1	21	For me to live *is* Christ, and to die *is* gain.
Philippians	4	13	I can do all things through Christ…
I Peter	5	7	Cast all your care on Him, He cares for you.
I John	2	25	He hath promised us…eternal life.
I John	3	2-3	Beloved, now are we the sons of God…

*All Biblical citations refer to their location in the authorised King James Version of The Holy Bible.

4.3.4.1 Life After Death Assurances

As already stated, the majority of participants identified that the Bible, both Old and New Testaments, were beneficial to coping through primarily providing "assurances" of there being a resurrection or life after death. As Linda, who found reading the Bible to be the most important religious resource in coping with the loss of her husband describes.

> Yes it was the Bible mainly with the assurances I mean right from the Old Testament and through there's this, this umm comments on there being something more, I mean for instance in Job [*Book of Job*], I read Job practically funnily enough while my husband was ill and found it very helpful but, he's saying 'I know my redeemer lives, and I will, though this body dies yet in my flesh I will see God' [*Book of Job, ch.19, v.25-26 – Job's Reply*], is from Old Testament times and certainly when you get to the New Testament with Corinthians with Paul saying you know absolutely, very surely that we will, there will be a resurrection, umm so Bible more than anything I think, that is the helpful thing on that line (L.574-582).

Linda followed this up further, again repeating the word "assurance" to describe Biblical afterlife content, while also highlighting the logic derived from Biblical accounts of the resurrection, that if Jesus can be resurrected then so can other people, including one's spouse.

> I mean in Christ saying 'I am the resurrection and the life', and John 'who believes in me though he be dead yet he will live' [*St. John, ch.11, v.25-26 – The Lord of Life*], you know I mean there's loads and loads in the Bible on that kind of line you know umm…that you think about, you think about these things I mean, there would be no point in Christian faith at all if Christ hadn't risen, and if Christ can be raised you know so can other people obviously (L.587-593). . .You see yes and it was all parts of this that I had umm (*flicking through the Bible*), 'and this is what Christ Himself has promised to give us eternal life' [*The First Epistle General of John, ch.2, v.25*], you see I mean the whole thing is on that kind of line…but umm there's 'eternal life in Christ'…(L.638-641). . .Yes, that there's an assurance of some kind of a resurrection and that we will be with Christ, I mean that's. . .the thing that makes Christianity as well different from, obviously different from other religions as well is Christ (L.652-654).

Similarly, the Biblical story of the Raising of Lazarus (*St. John, ch.11, v.1-46*) was also mentioned by several participants as providing assurance of a resurrection. As Anita describes, the story of Lazarus being brought back to life from the dead by Jesus is a powerful example of the resurrection, and was important to her in promoting feelings of hope in life after death, and also reaffirming belief in Jesus.

> You think about certain stories in the Bible, in the New Testament, Jesus' bringing to life of Lazarus [*St. John, ch.11, v.1-46 – The Raising of Lazarus*]. . .Well Lazarus was the brother of Mary and Martha, very great friends of Jesus who he visited often, and Mary was the one who sat at His feet and would just listen to Him, and Martha was very busy as a housewife getting everything ready, and Lazarus was the brother. And one day Jesus was somewhere else and a message came to Him to say that Lazarus was dying, would He come back quickly, but He carried on with His ministry or whatever He was doing and eventually when He did go back Lazarus was dead and had been buried in a tomb, and Mary was weeping and saying 'you didn't come, he was your friend' this and that and the other, umm and Jesus said 'don't weep', He went there

> back to the tomb and He said 'Lazarus come forth' [*St. John, ch.11, v.43*] and brought him back to life; and that gives me a great deal of hope that if Jesus is as it were on your side and is listening to you that things will turn out for the best, so I think of that story often (L.428-444).

A number of participants also highlighted passages that supported their belief in a heaven, for example:

> Oh yes because I mean Jesus said all along about you know I mean He said to the thief on the cross 'today you will be with me in paradise' [*St. Luke, ch.23, v.43 - The Penitent Thief*], didn't He, and He sort of…you know you got the feeling that He's giving people plenty of rope so to speak so that eventually you know He will gather as many in as possible, yeah (Christine, L.235-239).

In addition, a number of participants, including Catholics, used Biblical passages to reaffirm their belief that the dead would go immediately to heaven with no fear of a period of time in purgatory, and as such provided further support of there being an afterlife.

> The fact that one day one will meet one's husband again, I'm sure in a different sort of way umm but we do believe in being reunited as a Christian…And I believe that you know instantly you are in heaven, there's no purgatory (Elizabeth, L.471-474). . .there's 'absent from the body, present with the Lord' (*II Corinthians, ch.5, v.8*), instantaneous, I think somewhere it talks about 'in the twinkling of an eye' (*I Corinthians, ch.15, v.52*) doesn't it, in connection to that. . .well that death is not the end of life…but our life here is but a small part of life because eternal life just goes on doesn't it, eternally (Elizabeth, L.1141-1154).

Indeed, one of the most frequently mentioned Biblical passages that participants found helpful was from Chapter 14 of the Gospel of Saint John in which there is a promise of an afterlife by Jesus. This passage, which notably is also recited during the Christian burial service, appeared to provide participants with "comfort", a word frequently mentioned throughout interviews in relation to Christian belief and practice, which may reflect participants' sense of consolation or peace of mind derived from knowing the well-being or location of their spouse.

> The Gospel of John, but one chapter in particular, 14…umm…[*reading from the Bible*] 'do not be worried and upset, Jesus told them, believe in God, believe also in me, there are many rooms in my Father's house and I am going to prepare a place for you, I would not tell you this if it was not so, and after I go and prepare a place for you I will come back and take you there myself so that you will be where I am, you know the way that leads to the place where I am going' [*St. John, ch.14, v.1–4*], and I like that you see, that 'and after I go and prepare a place for you and I will come back', well I tell myself and in faith that

> my husband has gone, Jesus came back and took him there Himself you see that's how I see it, and I'm comforted by that (Beth, L.686-695).

4.3.4.2 Supporting Meaning-Making

A number of participants also described Biblical passages that helped them to make sense of their loss, and appeared to support benevolent religious beliefs involved in sense making (see Benevolent Religious Cognition theme). More specifically, Biblical passages served to reaffirm beliefs that events in life, including bereavement, unfold according to God's plan.

> My bereavement was something that was in God's, well it had to happen, it was part of God's plan as it says 'there is a time to be born and there is a time to die' [*Ecclesiastes ch.3, v.2*], and I look upon that as being in God's hands…really (Jane, L.455-458).

Similar Biblical passages emphasising life events being part of God's plan were also important in positive reappraisals of the bereavement, seeing the loss as happening for a reason, and finding some benefit in the loss.

> They help you yes but one's whole belief that life is in God's hands and that He doesn't allow anything to happen to us, there's a text isn't there again 'all things work together for good for those who love God' [*Romans, ch.8, v.28*], and although we can't see it at the time we look back and I think…I can see why that happened, if my husband hadn't died I wouldn't perhaps be able to do the work that I do now to the same extent (Elizabeth, L.1177-1182).

Furthermore, for other participants, Biblical passages reaffirming bereavement as part of God's plan helped participants in accepting their loss.

> You know 'the Lord gives, the Lord takes away, blessed be the name of the Lord' [*The Book of Job, ch.1, v.21*] umm that helps me a lot and that gives me hope and strength to cope…and that's never far actually from my thoughts…it just helps me accept that everything happens by His plan (George, L.197-201).

4.3.4.3 Regulating Symptoms of Grief

Passages from the Bible were also repeatedly mentioned by many participants as being used to cope with or in managing symptoms of grief, such as feelings of loneliness, anxiety, or fear.

> Well I think, the Psalms I think, tremendously, umm Psalm 46 'God is our refuge and our strength', or Psalm 23 'the Lord is my shepherd', Psalm 121 'I

> will lift up mine eyes and look unto the hills from whence cometh my help', umm…there are lots of them aren't there. . .Well again it's just the words isn't it saying God will help you, He will support you, be your strength umm…I'm trying to think now…'it's when I am weak then I am strong because of God' [*II Corinthians, ch.12, v.9*], umm 'I can do all things in Christ who strengthens me' [*Philippians, ch.4, v.13*] that was one that really helped give me strength and hope (Elizabeth, L.777-789). . .I mean there's another one isn't there, 'when you pass through the waters I will be with you' [*Isaiah, ch.43, v.2*]. . .Well if you're going through, it's just having the, I think the words really are the ones that give I think, you feel the presence of God with you, His strength being with you, supporting you, and being still and at peace, they're the ones, they're the words of the text that I would go to you know. . .Inner peace, yes, because you are in turmoil you know. . .that's why the repetition of them that I used to find, that helped me. . .yes, just stop sort of getting in a panic and umm getting too anxious, oh yes there's another one anxiety I mean, 'casting all your care on God be not anxious for anything but thy prayer and supplication, let your needs be known to God, and the peace of God who is passeth all understanding' [*I Peter, ch.5, v.7; Philippians, ch.4, v.6-7*], that's a lovely one isn't it (Elizabeth, L.867-903).

Indeed, the role of Biblical passages in combating feelings of anxiety and fear were also captured by Beth. As an aside this further serves to indicate that anxiety and fear, both under researched in bereavement and gerontology, may be more prevalent in older adults who lose a spouse after a long marriage than previously thought.

> Well there are lots of reasons I suppose really umm…I think, I think it's difficult to let go and umm I tend to be anxious, and I tend to be fearful and all those things and so reading the Psalms is very helpful because there you get changes of mood in who ever it is who's saying those words (*laughs*), of course who ever it is that wrote them, and expanding on how wonderful life is and so on and then suddenly saying oh but why are you hiding yourself God, where have you gone, and all those things so the Psalms really are enormously helpful, and there's a verse from one of them it says 'I will trust, I will not be afraid' [*Isaiah, ch.12, v.2*] and I know that I'm not a hundred percent trustful and I do feel afraid and umm so holding on to something like that 'I will trust, I will not be afraid' (L.565-574).

In addition to the rich and emotive language and content integral to Biblical passages, a number of participants also provided insight about the regulating mechanisms by which Biblical passages are used by the bereaved to exert their influence. The most salient mechanism appeared to be repetition.

> Yes well if you're reading a passage that says 'my peace I leave with you, my peace I give unto you' [*St. John, ch.14, v.27*] that sort of thing, sometimes a phrase will stay with you, for that day, umm and particularly if you run into problems because you know certain phrases in the Bible they come back into

> your mind and support you…like 'fear not I am with thee' (*Isaiah, ch.41, v.10*) you know if you're feeling particularly alone you know, claim the presence of God to be with you, perhaps repeat that umm more than once if you need it (Elizabeth, L.172-178).

At a superficial level perhaps, the importance of repetition in coping is similar to the process underlying some cognitive modification therapies whereby a more positive way of thinking, represented in this case by a comforting phrase, is repeated or reinforced over a period of time until the sub-conscious has assimilated this new way of thinking influencing a change in perception and emotion to be experienced. At a more simplistic level, Elizabeth, commenting on her use of repetition in coping with her grief, provides some support for this notion.

> I remember I repeated time and time again sometimes a phrase until it's really got in me, until I believed it as it were you know, taken it on board (L.811-812).

For other participants, Biblical passages were useful because the "great conviction" often expressed in Biblical scripture would transfer to the reader. Beth, an 81 year old Anglican who had recently been bereaved from her husband after 45 years of marriage, summed up the way Biblical passages were used and how they worked for many of the participants.

> Well it just helps in so many, many ways umm and I find myself you know sort of just going around doing the odd things and I'll just say something like you know 'the Lord is here, His spirit is with us', that's some words from the Communion service…I think it is helpful to think affirming things and say affirming things. . .Well yes I mean it helps you to keep going because the temptations to stop are very strong…the umm…so to, when the temptation is very strong I mean you can say 'well I will trust, I will not be afraid, I will trust, I will not be afraid' and that helps, yes (L.849-861).

Biblical passages were also frequently described in several ways as being used to cope with the feelings of being forsaken, of loneliness, or of human abandonment resulting from bereavement. These passages often helped participants by reaffirming feelings that the presence of God was with them, that God was a companion during grief, and that God through His creation of each individual knows the suffering they are experiencing.

> I no longer believe in coincidences, I believe that everything has a purpose umm and it's not predestined but you know umm…that your passage through life is known before, you know it says in a Psalm 'before you were…' you know 'I knitted you in your mother's womb' and you know 'before you even entered

> your mother's womb, I knew you' [*Psalm 139; & Jeremiah, ch.1, v.5*], that comes from one of the Psalms, I'm not quite sure which one it is…umm and of course the Psalms were prayers that Jesus Himself prayed…you know the famous one 'my God, my God why have you forsaken me' [*Psalm 22, v.1*] He felt abandoned. So I don't actually feel abandoned, I do sometimes, humanly I do but spiritually I don't umm and that's what I have to keep focused on, on that umm…you know I like to think that I can, by not feeling spiritually abandoned I can, that, that helps me to cope with feelings of human abandonment (George, L.434-446).

In addition, Elizabeth uses a poignant story from the Bible to counter the feelings that many bereaved older adults who lose a spouse after a long marriage often feel, that some how the purpose of their life ends as well. Elizabeth describes the "parable of the potter" (*Jeremiah, ch.18, v.1-7*) from the Old Testament that highlights how the Bible can be used to inspire bereaved older adults to realise that their hopes, dreams, and aspirations do not have to end when their spouse dies, but that God continues to have a role and purpose for them.

> You can do all things through Christ, you think 'oh I can't do that' you know 'I couldn't do that', but God will help you, it's putting your life into God's hands isn't it…another passage of scripture that's a great help to any Christian whether you're bereaved or not I think is Jeremiah [*Jeremiah, ch.18, v.1-7 – Parable of the Potter*], when he goes to the potter's house, and he sees the potter making a vessel and he mars it, it goes wrong, but I think the comforting thing is he doesn't get a new piece of clay and throw the other away, he reshapes the one he's got, and I think you know if you believe that God, what ever you do, and do wrong, and in bereavement I mean you do a lot of things wrong. . .but God can make something of your life…and will support you through it, and I think if you can take that on board then...you can still enjoy a new life with new meaning (L.1560-1572).

4.3.4.4 Light and Darkness

A different style of thinking during coping that was supported and facilitated by Biblical passages was the metaphorical use of "light" and "dark" to describe and make sense in a more simple way the complex emotions and thoughts experienced during bereavement and grief. For example, a number of participants made references to Biblical passages about darkness and light, comparing bereavement to darkness and the salvation they feel they receive from God, their faith, or the resurrection as light overcoming this darkness.

> It is easy to be overcome by the darkness of bereavement but it helps me to say the words that Jesus said, 'I am the light of the world, he that followeth me shall not walk in darkness, but shall have the light of life' [*St. John, ch.8, v.12*], and that helps me because I don't feel so alone, it makes the loss bearable and the

> grief isn't so sad, there is light at the end of your bereavement (Julia, L.546-551).

Biblical passages about light and dark also helped to ameliorate the distress of bereavement by providing the bereaved with a way to make sense, accept, and find hope in their loss.

> Well I find Psalm 139 very helpful, and one part in particular, umm I read Psalm 139 after my husband died…(*reading from Bible*). . .'if I say, "surely the darkness shall fall on me", even the night shall be light about me, indeed the darkness shall not hide from you, but the night shines as the day, the darkness and the light are both alike to you', and you see I find that helpful…that the darkness and the light are both alike to God, and this is a great help in understanding bereavement because to God death and life are the same, and we can't have one without the other, death must be accepted as something that isn't a tragedy but part of God's plan, there can be hope in darkness, and if God is with you, gradually the grief will be replaced by light and things will become clearer (Ellen, L.425-433).

In addition, for others, Biblical passages provided a way of finding strength and motivation to pull oneself out of the depression and sadness that often accompanies grief. The quote from Clare also contains the themes of light and dark, good and evil, and strength and weakness to make sense of coping with grief.

> When you're bereaved it's very easy to get sucked down into what I call the 'darkness of bereavement', and it's also very…easy to feel umm (*sighs*) that you have no reserves left, you're depressed, you're just weak, you're exhausted, and there's not much light at the end of the tunnel, but in Ephesians it says 'finally be strong in the Lord and His mighty power, put on the full armour of God so that you can see your stand against the Devil's scheme, and for our struggle against authorities, powers of the dark' and that sort of thing 'against the spiritual forces of evil' which I feel sometimes depression following bereavement is. . .Put on your armour of Christ and clothe yourself in God to try and umm…give yourself a weapon against depression. . .I think that in Ephesians, it's Ephesians 6, 10, the armour of God, it says 'stand firm then with the belt of truth buckled around your waist, with breast plate of righteousness in place and come with your feet fitted with the readiness that comes from the Gospel of peace', so you take up the shield of faith if you like and be ready. . .I think in some cases of bereavement and grieving and going through that process is like in getting the armour of God around you again, getting bathed in His light, taking onboard His clothing of light if you like and getting out there and girding yourself, making yourself strong again, because it doesn't matter what other people try to do for you and they might make nice sounds, and nice words, and comfort you, and be with you which is smashing, it's really, really helpful and useful, but it really is down to the individual person when they are ready to you know get themselves armoured up if you like, and sword in hand, go out

there and fight again, because I think that is sometimes how it feels to people, well it did to me (L.1384-1410).

4.3.4.5 Understanding One's Suffering

During coping a number of participants also remarked on being able to use Biblical passages to help understand and make sense of their suffering, often perceiving that their suffering was known to, or allowed by, God and therefore in some way increasing their sense of coping self-efficacy by allowing them to view their suffering as manageable or accomplishable.

> I don't know where it comes but anyway, I think in Saint Paul's somewhere, one of Paul's passages you know he said, 'God, He never puts us in a situation which we can't actually overcome', [*I Corinthians, ch10, v.12-14; & ch.14, v.33*] we may not be able to do it on our own but we need to do it with His help, we need to recognise that…that is…that it is His help that actually enables us to overcome our trials, and to cope with whatever cross, again now this is the other aspect of it you know there is no salvation without the cross, there's no way to heaven without the cross, umm and that's sometimes the difficult one to grasp (George, L.99-106).

Similarly, Biblical passages also allowed participants to believe they could work in partnership with God during coping or defer their coping to God when they felt overwhelmed.

> Suffering, absolutely yes, if He can put up with it you know, He wasn't…He wasn't immune from that, that kind of suffering, and His suffering was so much more than what I've had to put up with in my life, and one of my favourite sayings is that 'God doesn't give you any more suffering than He knows you can cope with' [*I Corinthians, ch10, v.12-14; & ch.14, v.33*] umm…and…I've tried, I tried to cope because I know that you know if it gets too much for me I just put it in His hands and say 'look this is getting too much for me, I can't cope with this anymore', you know, 'I'm going to lay it back on your door step please', you know 'please give me strength to find ways of coping with this' (Clare, L.649-657).

4.3.4.6 Identifying with Biblical Characters of Suffering

One of the most frequently mentioned and innovative ways participants described using Biblical scripture during coping was in identifying with Biblical characters of suffering, and specifically those related to suffering as a result of death, bereavement, or grief (e.g. Jesus, The Virgin Mary, Job, the Disciples, also Saint Paul). These Christian figures of suffering or grief described within the Bible helped participants to understand, make sense, and find benefit in their experience of suffering primarily through the process of downward comparisons that served to minimise how participants perceived their own suffering. In addition, the Bible offers

assurances about the forthcoming of help or support through the examples of God helping other characters in their time of suffering.

> You can put yourself alongside somebody and say well 'they were going through what I am going through' umm they came through it, God helped them, I mean look at Job for instance with all his problems. . .Well he lost his family, his health, his friends, everything, but he still said 'I know that my redeemer liveth', he didn't lose his faith…[*Job, ch.19, v.25*]. . .I think as you read a story like that you think 'well, you know God helped him, He saw him through, and He'll see me through', you empathise really. . .I mean Saint Paul was another wasn't he, he suffered a tremendous lot umm, look at his faith and what he did. . .well of course Paul was very anti-Christian and then he had this experience on the road didn't he, umm but somewhere it talks about the 'thorn in his flesh' [*II Corinthians, ch.12, v.7*]. . .so they experienced suffering as well that was so much worse than mine (Elizabeth, L.711-739).

Perhaps unsurprisingly, by far the most frequently mentioned character's suffering that participants identified with was Jesus' suffering on the way to and during the crucifixion (often referred to in Christian doctrine as "the Passion"). By comparing their suffering or the suffering of their spouse with that of Jesus, and the significance of Jesus' suffering, participants were able to minimise the distress associated with their own suffering and loss. Furthermore, the Biblical accounts of Jesus' suffering and dying for the sins of mankind could be personalised and become a powerful motivating factor in encouraging self-efficacy and determination to cope.

> I think if you believe that His suffering was for a reason then you can compare your own suffering which is transient because you're still alive, the person that you're bereaved by may have gone through suffering again that could be compared to the suffering of Christ and I think that…if you stand there and say 'well my suffering is nothing in comparison to that of Christ, you know if He can do that for me then I can get through *this* for Him and for myself as well,' and so I think in that respect it can help…but you have to take comfort in the thought that God's gone through it as well in Jesus (Clare, L.1582-1589).

A smaller number of mainly Catholic participants were able to identify with the suffering and grief experienced by the Virgin Mary in witnessing her son's torture and death. Again, participants, through comparing their loss with that experienced by the Virgin Mary, were able to find benefit and perceive their loss as less negative.

> Yes, Our Lady seeing her son suffer and seeing Him die umm…yes I suppose I've identified with that, and I've seen my son die and my partner die, and so I can, I can imagine how she must have felt, although her experience was so much

> more painful, painful than mine, but we are, I do identify with her in this bereavement experience (Timothy, L.730-734).

Furthermore, in discussing the 14 Stations of the Cross, a religious ritual based on the Biblical account describing Christ's suffering, crucifixion, and subsequent resurrection, Anita captured the implicit thinking of many participants in finding some benefit through recognising that God and the Virgin Mary (who importantly is prayed to in the Catholic Church) would understand human suffering during bereavement.

> One of the things that I remember well in the Stations of the Cross where you've got I think…the tenth [*station*] He's stripped of His garments, eleventh He's nailed to the cross, twelfth is He dies on the cross, and there's Mary His mother and there's John the youngest disciple and most beloved by Jesus who are both by that cross and Jesus tells John to look after Mary [*St. John, ch.19, v.25-27*], what a wonderful thing for a dying son to say and entrusting it to a disciple who He was very fond of, and to take care of Mary, and I think that is a very beautiful memory of the Stations of the Cross. . .So, yes, so lots of Stations of the Cross where I could be remembering where He meets His mother along the way and I can just imagine that anguish, mother and son meeting up but then it gives me the feeling that they were human beings too, Jesus was man and God, and they had the feelings that we have and they would understand how *we* would feel in our own sorrows and whatever you know, so that gives me great hope (L.463-478).

The example of how religious ritual such as the 14 Stations of the Cross can evoke pathos, sorrow, empathy, joy, and hope in response to the depiction of Christ's suffering, death, and subsequent resurrection, is something that is examined further by the next theme of religious ritual.

4.3.5 Religious Ritual

Although the present study was interested in the religious practice of participants, for example church attendance and prayer, a significant emphasis remained on identifying the content of religious cognition that was most important in coping. However, in early interviews it soon became apparent that at a more specific level than general religious practice, religious rituals including receiving and attending Communion/Eucharist, reading the Bible, and candle lighting, were spontaneously mentioned as being used in coping. Therefore, in the early stages of interviewing participants, items investigating the role of religious ritual were more explicitly incorporated into the interview schedule to focus in on the use of religious ritual in coping. Within the philosophy of IPA because this phenomenon of the participants' experience emerged spontaneously it is given considerable validity and significance.

Table 8 shows the percentage of participants that reported specific religious rituals as helpful in coping. For nearly every participant, daily prayer was in some way mentioned as helpful in coping, while the ritual of attending and receiving Holy Communion or Eucharist (depending on participant denomination) was also described in various ways as helpful. Interestingly, over half of participants found reading Biblical scripture helpful, while over a third of participants found candle lighting beneficial. Approximately, one-fifth of participants (all Catholic) found the rosary (i.e. prayer beads) helpful, while only four participants reported meditation as helpful.

Table 8.

Number and percentage of participants who reported specific religious rituals as helpful in coping with bereavement from spouse

Ritual	N	%
Prayer	25	96%
Mass/Communion/Eucharist	24	92%
Reading Biblical Scripture	16	61%
Candle Lighting	11	42%
Rosary	5	19%
Meditation	4	15%

The role played by individual rituals is described within the overall use of religious ritual in coping at the cognitive, emotional, and behavioural levels. However, attention is drawn to the use of specific rituals where relevant. As prayer was described as important to nearly every participant, and because prayer was used within or in conjunction with other rituals (e.g. during candle lighting, during use of the rosary, and during the Communion/Eucharist service), prayer deserves specific consideration.

4.3.5.1 Prayer

The majority of participants described prayer as a way of "communicating" or "talking" with God, or as a "relationship" with God. Prayer nearly always took the form of either talking

aloud or silent thought, and was mostly said in the participant's own words; participants rarely described using a prescribed prayer (e.g. the Lord's Prayer). Prayer was most often described as being conducted privately, either at home, while out walking, or in church, but was also engaged in communally during church services. For most participants private prayer was said during set times of the day, with the most frequent times being first thing in the morning on waking or last thing at night, however prayer was also said during the day as and when an incident or thought occurred that was worrying or anxiety-provoking. The content of prayer often took the form of petitions to God, while during coping one of the most frequently mentioned uses of prayer involved asking God for strength to cope.

> Well feeling that God was there, that there was some power there which was helping you know, which gave you strength you know, that's what I really mostly ever prayed for, was the strength to carry on as it were you know, for strength to get through another day sometimes (Jane, L.233-236).

An additional use of prayer involved participants praying to God for guidance during the course of coping. Prayer was also frequently used by the majority of participants to ask God to look after and care for their deceased spouse. Interestingly, prayer was also frequently mentioned by both Catholic and Anglican participants as a way of communicating with and asking their deceased spouse for help.

> What I benefited from myself is prayer, prayer *for*, and prayer *to*, to get that inner strength. . .*For* – you ask Our Lord to have mercy on the soul of my wife or the bereaved, and you ask the deceased, in my case my late wife, to help members of the family…And you are asking them if they can to help whatever your cause is (Roger, L.541-561).

This underlying and implicit belief in a "two-way link" between the bereaved and the deceased was common to the majority of participants, although a small number of participants recognised that praying to their deceased spouse for intercessions was not explicitly approved of within their religious practice. However, the perceived protection from the deceased spouse or the ability of their spouse to intercede on their behalf and help them was considered helpful and comforting by most participants.

> I know some people say you shouldn't, you know you should let the dead rest in peace, but I do pray to my husband, and I know he won't let anything bad happen to me, and I know he is up there protecting me, and when I get worried or get anxious and you do when you live alone, or if I have any problems, I pray to Daniel to help me and to keep an eye on me, and that always helps me to feel more calm (Ellen, L.691-697).

Indeed, the implicit belief of many of the participants that on some level their deceased spouse could help them, or that through religious ritual (e.g. prayer) participants could commune with their deceased spouse was perhaps influenced or motivated by the theological belief entitled *Communion of Saints*, which is affirmed in The Creed, the summary of Christian beliefs that is often stated aloud during church services. According to this belief, "faithful Christians who have died still enjoy a relationship with believers on earth" (Browning, 2004, pp.75). The role of this belief in religious ritual is explained further by Philip, a 78 year old cradle Catholic, in relation to the Communion service and coping with his recent bereavement from his wife after 52 years of marriage.

> There are Masses which can be said on the various intervals after the beginning or at the beginning of the bereavement and I commemorate the annual Mass, I have a special one said especially for Victoria. So, you see these things not only help they maintain what's known as the communion of saints, do you know what that is? Well it's the unity of those who are as some say in heaven, now that's a term that is debatable, and ourselves here, the communion of saints it comes from the Creed, 'I believe in God the father Almighty', well at the latter end it says 'I believe in the holy ghost, the holy Catholic church, and the communion of saints', yes well that's what it helps to maintain you see, so that who ever you have lost, daughters or wife, you are able to be part of their company still. So there you are that's what it does (L.260-270).

Awareness of this belief is important because for the majority of participants the belief that deceased loved ones are in some way still accessible or obliquely present was involved in how the participants psychologically and emotionally engaged in certain religious rituals during coping with grief, with some participants more conscious of this in their religious behaviour than others.

4.3.5.2 Continuing Bonds with the Deceased

By far the most frequent way religious ritual was described in relation to coping and adaptation to bereavement was in providing a way of maintaining or continuing the perceived relationship with the deceased spouse. This continuing bond with the deceased (Klass et al. 1996; see section 1.10), was most often referred to as a "link", "bond", "closeness" or "attachment". Moreover, in continuing the bond, participants described using religious rituals in diverse, flexible, and adaptive ways depending on the cognitive or emotional needs of the participant. Although in continuing the bond each of the different religious rituals already

listed were in some way used, the most frequently mentioned and most potent rituals in this regard appeared to be the Communion/Eucharist service, and private prayer.

> I pray for her every day umm I will…at odd moments talk to her you know that's umm…so there is that, that kind of attachment (Terry, L.815-816).

The content of prayer used in continuing the bond felt toward the deceased spouse often involved emotional expressions of love or affection, and a desire to see the spouse again some time in the future. As Christine describes:

> I just say, it's quite simple really…I sort of just tell him that I love him and…miss him, yeah, and that I look forward to seeing him again (L.787-788).

For others, religious rituals that may have been performed together when the spouse was still alive were also used to provide a way of continuing the bond.

> We used to say it [the rosary] together, umm my wife and I used to say our rosary together for some good reason, so we were joined in that, and uhh there you go, you know, I still feel united with her in saying the rosary on my own (Timothy, L.698-700).

Many participants also felt that they continued the relationship with their spouse through the continuation of church attendance and keeping the same routine, even down to the seats that were sat in.

> I pray for her [wife] and I hope she prayers for me, I feel in a relationship with her still, so that we have this bond on a daily basis, that umm, I sit in the same seat we always sat in, and you know we're reunited on a daily basis in anticipation of the great reunion, yeah (Timothy, L.8-11).

A significant continuing bonds experience for a number of participants that was specifically felt during the Communion/Eucharist service was of a perceived three-way link between the bereaved and the deceased that operated through God; as Linda describes:

> They [the deceased] are close to God and that in Communion, that's it, you are close to God as well so there is, there is that kind of closeness. . .there is a link, yes, yes (L1127-1130).

Furthermore, when this perceived link is experienced it is emotionally comforting and helpful to the bereaved, and understood at more of an emotional than psychological level.

> I do very much feel that when I'm receiving Communion that I'm coming linked with the Lord and if she's there as well in His presence then there is that very strong link and that's comforting umm…You can't intellectualise it but it's something that is you know deeply, that you feel deeply, and again yes that helps me, that helps me…I feel she is close then (George, L.456-461).

A further elaboration on the perceived sense of continuing a bond that was frequently mentioned was the feeling of "closeness" felt toward the spouse through religious ritual. Furthermore, that for some, religious rituals were more unique in facilitating a continuing bond than other grief activities.

> Well I suppose just being able to go to Mass, I hadn't always gone to Mass everyday but umm, because he went to Mass everyday, now I go because I just feel so close to him when I do that…I go up and tend his grave for instance but it doesn't uhh it doesn't mean anything to me, I mean I've got a friend who goes up there and she cries over her husband's grave all the time but it doesn't affect me like that because I know he's not there…it's just a case of keeping his grave tidy as a sort of remembrance to him but I don't do it because I think he's there or anything (Harriet, L.487-493).

A number of participants also expressed a sense of closeness through maintaining the church routine that was established prior to bereavement.

> Yes and of course we used to go to church together and you know, that yes it was part of, it has been like a bit of a ritual isn't it, because we went to church together, we, you know we did everything together and I wanted to keep all that going because that was, I would be near him all the time (Sarah, L.858-861).

4.3.5.3 Maintaining a Routine

Indeed, at perhaps a more practical level, the role of religious ritual in maintaining a daily or weekly routine was frequently mentioned as being helpful to coping. The preserving of pre-bereavement behavioural patterns provided by religious ritual seemed to be helpful by encouraging "normal" behaviour patterns or "continuity" or "constancy" during a time of emotional turmoil. Furthermore, religious ritual encouraged the bereaved in "keeping their mind active", an avoidant coping strategy that is frequently mentioned as beneficial (Stroebe & Schut, 1999), that reduces the amount of unnecessary cognitive processing or rumination about the loss.

> I think one of the things that helps is keeping to your routine you know, like going to Mass. . .I suppose it helps by keeping your mind active, and carrying on in your normal, everyday life as you had before really (Sandra, L.990-995).

An additional way maintaining a ritual was reported as important to coping was in providing motivation and purpose for daily living.

> It is very important to me to get out of bed at a reasonable hour and think well I've got to be there [at Mass], because this is an opportunity to pray for her and for Robert [Timothy's deceased mentally handicapped son] and umm it's the best thing, it's the most useful thing I can do for her you know, I still feel I'm caring for her (Timothy, L.325-329).

For others, the performing of religious ritual itself was enough to "carry" the participant through the aftermath of bereavement. Philip uses the simile of "tram lines" to describe how religious ritual carried him during the first 18 months immediately following his bereavement.

> So I then entered into a state of existence like living in a bubble, the world was out there, anywhere around, 360 degrees in every direction, but I was inside and far from it. That lasted for a long time, about 18 months, this withdrawal, but during that time there were of course the Masses and other, I would say religious practice which went on…so there was a continuum…as I say the religious practice sustained me, it carried me through my grief like tram lines (L192-198).

4.3.5.4 Remembrance

An additional way religious ritual was used to maintain a bond was through providing ample opportunity for remembrance, and especially remembrance of a sacred or transcendent nature. This kind of remembrance is most evidently demonstrated during the Communion/Eucharist service, either daily or on anniversary dates throughout the year. As Elizabeth describes:

> Well there is in every service a prayer for those who have died, and those whose anniversaries fall at that time, and silence for you to remember them at every service (L.1611-1612).

The Communion/Eucharist service was also described as being engaged in specifically in remembrance or reverence of the deceased spouse.

> Well it's the fact that He said do this in memory of me, Jesus said you know, but I mean of course you can also do it in memory of your husband you've lost can't you, yeah, although he isn't like Jesus I know (Christine, L.1596-1598).

Furthermore, the act of remembrance incorporated into the Communion/Eucharist service also elicited positive emotion and psychological well-being during grief.

> Well at every service we always pray for those who have gone, the whole congregation prays, so they are remembered and those are happy, positive moments for me because…it means that they aren't forgotten, it's not as though they were never here, they are still here in a way, plus we believe praying for them helps them in whatever they are going through in the afterlife (Ellen, L.531-535).

4.3.5.5 Helping the Deceased

Indeed, religious ritual was frequently described by both Catholics and Anglicans as a way to help the deceased in their afterlife existence or progress, and this offered the bereaved a feeling of control, pro-activeness, and purpose during the turmoil of grief.

> I have a service dedicated to him on the anniversary of his death, you know, I light a candle in church for him every Sunday, and I pray for him everyday as well you know, for his soul to rest in peace, umm…I do feel that this can help him and in a way that helps me because...I feel I can still do something to help him, you know I can still be of purpose to him in a way (Charlotte, L.446-451).

A similar example of using religious ritual to help the deceased was by Clare who used candle lighting as a way to focus prayers and thoughts concerning helping her husband enter into heaven.

> I think lighting a candle is quite important to me, it actually reminds me and focuses, it gives you an action to focus on. I mean some people kneel, hands together and pray umm but the physical action of lighting a candle and focusing on the flame, and the light helps you focus your prayer, your thoughts or whether it's a prayer to God or whether you're thinking of the person you're lighting a candle for, you're asking God to accept their spirit into you know into His domain, and I just think it's an act of helping and…reverence really (L.1150-1156).

4.3.5.6 Emotion Regulation

One possible mechanism that underlies and links the different ways that religious ritual is involved in coping with bereavement is emotion regulation - that is religious ritual can evoke and influence what emotions the bereaved are likely to experience at a specific point in time during their grief. Indeed, a number of participants described religious ritual, especially the Communion/Eucharist service, and the 14 Stations of the Cross as particularly emotional. For many participants attending church services was a highly emotional experience especially following bereavement.

> Yeah well you would control them, your emotions, your grief, but I mean I used to *feel* perhaps sometimes more emotional during a service you know definitely, it sort of umm…brought things home you know, and you know you could feel quite close to tears sometimes you know…especially with Communion you know (Jane, L.1000-1004).

Furthermore, several participants articulated often turning to specific religious rituals when they were feeling upset and that engaging in rituals would improve their mood. For example, for Charlotte candle lighting was an important religious ritual that allowed her to express grief-related emotions that she was feeling and would leave her in a more positive state.

> If I am feeling depressed or upset, or if I want to cry, I will quite often light a candle for him [husband], and other relatives, and think about them, they've all passed on now, I feel it allows me to express my sorrow and grief for them, and once I've done that and got it out of my system I start to feel better again, and I feel calm and more cheerful again, you know and I can get on with things. So lighting candles and having a good cry helps (L.390-396).

In a similar way, church attendance was also often described as encouraging positive emotion during the grief process.

> I think sometimes we had a mid-week Communion when just a handful of people go and I think sometimes in the early days it's easier to go to a small service where there's just very few people, you're not overwhelmed, but just some time, just the worship and the singing, just the whole thing, it lifted you really (Elizabeth, L.1057-1060).

In addition, for a number of participants religious ritual such as prayer and meditation were described as encouraging feelings of calmness during grief.

> I found prayer in church, quietly by myself, with nobody else around very calming and helpful, I felt very at peace doing that, it would take my mind off what was going on around me, it felt like the calm in the eye of the storm if you like (Ellen, L.629-632).

Similarly, meditation, although mentioned as being used by only four participants in coping, was a religious ritual of sorts that was in different ways also described as producing feelings of calmness and as a way to distract one's thinking away from thoughts of grief, even if this was only momentarily.

> Oh yes definitely, because, well I've still got the [meditation] group you see who come here and umm…it's difficult to say in what way it helps but it definitely does…The meditation calms me down certainly and I think just for a short time

> allows me to empty my mind of thoughts, it takes my thoughts away from my grief if you like, I find it very, very helpful (Beth, L.1147-1151).

4.3.5.7 Emotional Catharsis

A number of participants also described a cathartic quality in relation to religious ritual. Specific religious rituals such as attending church services and the 14 Stations of the Cross were highlighted by a number of participants as helping them to release, ventilate, or express grief-related emotion concerning their bereavement in response to emotion provoking content mentioned within these religious rituals. Ellen describes the cathartic process involved in attending church services:

> I couldn't show how I felt around family you know but I found going to church very emotional after my bereavement, you know singing hymns about heaven made me cry, receiving the Eucharist and feeling close to God was very moving, you know, umm it could all make me cry but I'm sure it helped me because I always felt easier in myself for going, I still do…I think it can bring your emotions to the surface, it can help to get some of the grief or sad feelings, you know the tears out of your system, I know it did for me (L.771-777).

Furthermore, for a number of both Catholic and Anglican participants, the 14 Stations of the Cross both as a ritual and a Biblical story, with its affectively charged content of suffering and loss, was described as evoking pathos and sorrow, that encouraged a cathartic release of grief-related emotion.

> It was only when I thought about the Stations of the Cross in church during one Lent when it was performed, you know the terrible suffering and the sadness of the loss, was I really able to cry about my own bereavement, and that helped me feel better, I think I really unloaded a lot of my grief through thinking about how sad that was, and I still think about that regularly (Julia, L.728-732).

For others, the ritual of the 14 Stations of the Cross allowed some to identify with the Virgin Mary and the emotional suffering and bereavement that she experienced and in turn this helped them to express their own grief.

> I felt that umm more than anything she [The Virgin Mary] would understand grief, wouldn't she. . .I just felt that Our Lady sees it from a woman's point of view, she can, she would understand how a woman copes afterwards as well you know. . .I feel she'd comfort me and she did comfort me umm…she would put her arms around me and help me to cry probably and get it out of my system (Catherine, L.788-803).

4.3.6 Spiritual Capital and Growth: Identity Change and Sense of Self

This theme represents two related but distinguishable aspects of religiosity that in different ways influenced identity change and sense of self following spousal bereavement. The first, *spiritual capital,* represents the roles, jobs, or activities performed by participants within their local community church that they took up following their bereavement and have helped participants to gradually reconstruct a new, purposeful and meaningful identity (c.f. Iannaccone, 1990; Stark & Fiske, 2000). The second, *spiritual growth,* represents how following bereavement nearly every participant reported some kind of growth in their religious or spiritual beliefs and practice, and that this growth influenced participant sense of self, pro-social behaviour, and the importance and meaningfulness of religious beliefs.

Consistent with meaning reconstruction theory, nearly every participant was able to identify a number of changes in their sense of self or identity directly as a result of their bereavement, for example feeling like an individual rather than part of a couple, and in taking on the status of widow(er) rather than wife or husband. Furthermore, consistent with previous research by Tedeschi and Calhoun (2004), the majority of participants described feeling an increase in positive characteristics such as confidence and autonomy, and in feeling like a "stronger person". These changes were primarily through having to cope with different aspects of their bereavement and through having to take on the tasks previously performed by their spouse (e.g. doing house and car maintenance, finances). In addition, the majority of participants were able to describe a number of ways in which religious-based activities had influenced their sense of self and identity following their bereavement.

The term spiritual capital is used because it represents how the church, at a certain level, can be viewed as a source of community wealth or capital that all church members can own through investment of personal time in performing jobs, roles, or activities on behalf of the church. For example, in the present study, following the bereavement of their spouse more than half the sample took up unpaid jobs or roles, or increased the number of roles they performed, related to the functioning of their local church. Such roles included being a welcomer, sacristan, reader, lay pastor, catechist, Eucharistic minister, church warden, member of the parochial parish council, and member of the Union of Catholic Mothers, to name but a few. Importantly, these roles and jobs had gradually come to be integrated within the participant's post-bereavement identity, through which they could be identified by others and could come to identify themselves. Essentially, the pay-off for bereaved older adults of invested time in the running of the church is the new purposeful identity, confidence, and autonomy that

participants receive from performing these tasks. The description by Julia, an 86 year old widow, captures some of the benefits experienced by many of the participants who became involved in church-related duties following their bereavement.

> I really feel that since my husband, since Robert died, my identity has become centred around the church, I spend everyday in church working on something or other…I'm, umm I have to remember them all now, I've been a sacristan, I'm on the PPC, I prepare the coffee mornings after every service, I pick up the elderly ladies who can't get to church and I take them all home, I'm a lay pastor, I visit the sick and suffering, I do occasional secretarial duties in the church office, and…umm that's really how I see myself now, as part of the church you know…I enjoy doing all these jobs as I never had the opportunity to do all these things before as my husband didn't want me spending too much time doing things out of the house, you know, he mainly wanted me to be at home…I, I was overshadowed by my husband really…I think if my husband were to come back now he wouldn't recognise me, he really wouldn't recognise me (*laughs*), umm because I've changed so much, I feel more confident now, and I've been able to stand on my own two feet more instead of relying on him all the time…Umm, I feel like a different person now, I think I've become a more rounded, a fuller person really you know since Robert died, I've certainly got more purpose in life now…I never used to do so much before when Robert was still alive…I think since my husband died I've been able to live my Christianity more through the church which gives me great purpose, I think it keeps me going at my age (L.350-367).

For the majority of participants engaged in roles on behalf of the church, the loss of their spouse offered them the time and opportunity to invest in different areas of spiritual capital.

> Because I haven't got him I think I have been able to do things umm that perhaps I couldn't have done before because perhaps you've more freedom (Elizabeth, L.1183-1185).

Amongst the changes in identity and sense of self related to spiritual capital reported by participants was the new sense of "purpose", "meaning", or "focus" in the participant's ongoing life, while at the same time spiritual capital also helped to counter negative grief-related thoughts aroused by spousal bereavement such as life being meaningless or empty. For some, particular roles such as being a lay pastor which involves ministering to the sick and frail allowed a new perspective on one's suffering and bereavement to be established through downward comparisons. Elizabeth describes the above processes and the new sense of purpose and perspective gained, and about how she became involved in the spiritual capital of the church following her bereavement.

> I remember on one occasion saying [to the vicar] can you come up, it was the previous vicar umm I'd like to have a chat, and he'd come up you know and you chat, and then I remember on this occasion I said well...that I would like a job as it were to focus on and I remember him asking what, and I said oh something to do with people, not sitting at my computer doing something on my own, I needed people, and I was given the job of welcoming newcomers to the church which I still do (*laughs*), which I find very, very useful. It's things that give you a focus and a purpose in going on with life, because you can think 'what's the point of going on', you know, 'I lost the one I love so life is meaningless', you need something to replace that. . .what we have started recently is lay pastors, which, we've gone through a training for visiting people umm whatever the different circumstances, you know they may be new, they may be bereaved, they may be in a nursing home. . .I strongly believe that in helping others you help yourself very much so, you gain a lot from it, partly because you sometimes see somebody that is in more need than you are, and it gives you a different perspective doesn't it, you know, what am I worrying about you know look at them they are really suffering (L.1108-1131).

For others, the increased free time to engage in church related tasks resulting from bereavement was interpreted in a benevolent way, as a God sent replacement activity that could be used to counter feelings of grief, and the sorrow elicited by the loss.

> It seems that God has taken something away but He's put something in its place to give me a purpose. . .I've now got more time and I lose myself in these activities which is a great help because instead of sitting here and crying in my beer and regretting what's gone by, I'm reaching out to umm…find a replacement, a replacement activity (Timothy, L.553-581).

Furthermore, for several participants the new freedom and time to engage in church-related tasks allowed the bereaved to pursue their own spiritual or religious development in a way that they may not have been able to before due to family and marriage commitments that took priority. In turn, the opportunity to spend more time engaged in religious pursuits was interpreted as a benefit of the loss in itself.

> I'm a Eucharistic minister at church and that is very important to me, that has been a real privilege actually because I think the Eucharist is the most sacred and spiritual of acts, so that has been a great help to me really, I've taken on that role since my husband died…umm and it gives me a huge sense of purpose and responsibility that I never had in quite the same way before, you know I'm needed by the church and the congregation…and I think it's allowed me to grow spiritually in a way I never experienced while I was married…so, so...I can pursue my spiritual interests more now than I could before which is a blessing really (Charlotte, L.501-510).

4.3.6.1 Spiritual Growth

With regards to what is often referred to in the psychology of religion and bereavement literature as "spiritual growth", the majority of participants following their bereavement articulated in different ways some kind of positive increase in the importance or meaningfulness of their religious beliefs and religious practice. The majority of participants described their beliefs as becoming "stronger" following their loss.

> Following the bereavement I would say…my faith has grown most certainly stronger and I have a greater belief and a more intimate awareness, closeness to Our Lord (Roger, L.649-651).

For a number of participants spiritual growth took the form of feeling closer to God directly as a result of their bereavement. Timothy captures the sentiments of many of the participants.

> Through the loss of Margaret I am closer to God, He took her away and I've drawn closer to Him as a result, no doubt about it, no doubt about it. Umm, you know it's a great blessing and I, you know, I sort of feel that this is part of the purpose (L.930-933).

In addition, the majority of participants following their bereavement also remarked experiencing an increase in their religious practice, specifically prayer, and this was partly because they were praying on behalf of and for the well-being of their spouse (see Religious Ritual theme).

> I certainly did pray a lot more for my husband and for the repose of his soul (Anita, L.512-513).

For the majority of participants, religious rituals such as prayer were described as becoming more "profound", "sincere", "earnest" and "meaningful" following their bereavement.

> Well I would say [my belief] it's stronger, I would say it's stronger because I have no doubt my prayers are now perhaps more meaningful (Terry, L.962-963).

For a number of participants, one of the explanations or reasons for the increased importance and meaningfulness of their beliefs and practice following their loss was because of their need to draw on their Christianity as a coping resource.

> I hope [my beliefs] they're stronger because I've had to…call on them more perhaps, I've needed them (Elizabeth, L.1300-1301).

For others, their religious beliefs had become more important because of the belief that their spouse was in an afterlife dictated by their faith. Furthermore, there was the implicit belief that their spouse was now in some way in closer proximity or more closely linked to God, and consequently increasing the perceived proximity or access of the participant to God.

> I almost felt as though Neil had gone before me and opened the pathway for me, and so I found it easier to commune with God if you like because he sort of had been the channel if you like. . .it was just the fact that he gave me a reason or a umm a reason or a…or a need to actually like, you know have a relationship with God (Clare, L.397-402).

Interestingly, although the importance of participant beliefs had increased following their bereavement, nearly every participant reported that the content of their beliefs had remained stable and not changed; that is participants reported still believing in the same beliefs they had believed in before they were bereaved.

> I don't think they changed, they became deeper, so my beliefs didn't change, I still had all the same beliefs that I always had but I found them much more profound and much more meaningful and much, much deeper emotionally (Clare, L.387-389).

Finally, several participants articulated that following their bereavement they felt an increased sense of altruism and a desire to help other people who may be suffering or in distress.

> One positive thing was that following Alan's death umm I did feel very strongly that I wanted to help other people in some way who were in distress because I know what that's like, umm, I was determined to help other people really, umm and to be the best Christian I could be, so one of the first things I did was to become a volunteer at the church (Charlotte, L.540-544).

4.4 Discussion

The present study had two related aims. First, was to identify the content of religious belief and the religious practice that was most important or beneficial in coping with spousal bereavement and how belief and practice are translated or converted into specific modes of coping; and second, to investigate how religious belief and practice are related to the core components of meaning reconstruction, thought to be central to grieving. The results from the present study revealed that religious older adults were able to draw on multiple dimensions of their Christian religion in order to cope and make meaning from their experience of spousal bereavement. The most salient dimensions included benevolent religious beliefs, use of religious scripture, use of religious rituals, and spiritual capital. How the present study proposes that religion is translated into modes of coping is through benevolent religious cognition facilitating meaning-making processes (i.e. sense making and benefit finding); Biblical assurances supporting meaning-making processes; religious rituals facilitating the expression of grief related emotional needs and emotion regulation; and spiritual capital encouraging positive post-bereavement changes in identity and sense of self. These processes are discussed further below.

4.4.1 Benevolent Religious Cognition: Meaning-Making

The concept of benevolent religious cognition represents an attempt to unify and capture the most important religious cognition involved in coping with loss. Benevolent religious cognition encapsulates the thought processes related to three main Christian beliefs (i.e. belief in God, belief in life after death, and belief in a life after death reunion with spouse) that emerged as most helpful to coping and from which sense making and benefit finding about one's loss could be established. The most frequent use of benevolent religious cognition in making sense of spousal bereavement was in interpreting the loss as happening for a reason known to God or as part of God's plan either for the bereaved, the deceased, or both parties. Believing that the loss happened for a purpose known to God and perceiving God in benevolent and caring terms (e.g. protective, merciful, forgiving, gentle) were involved in the cognitive acceptance of the loss and helped ameliorate negative thoughts or feelings. These benevolent beliefs also influenced positive post-bereavement re-appraisals of the loss in terms of the loss being less negative, and being related to God guiding the participants' ongoing lives.

Benevolent religious cognition also facilitated optimistic interpretations to be made about the perceived continuation of a relationship with the deceased spouse and of eventual

reunion with the spouse. Similarly, benevolent religious cognition countered the tendency of participants to believe that the death of their spouse was final and severing the relationship with the deceased. Furthermore, the belief that their loss was in some way temporary and that there would be a future reunion encouraged feelings of hope and optimism which made suffering and coping with grief more bearable. Indeed, benevolent religious cognition encouraged fortitude in coping through the belief that present suffering would ultimately be compensated for with a reunion in an afterlife. This latter belief was reinforced by Biblical assurances of crucifixion being followed by resurrection. The most frequent use of benevolent religious cognition in benefit finding involved beliefs about some kind of heavenly afterlife, and believing that the deceased spouse was in a safer, better place (i.e. heaven), free from pain, and no longer suffering.

4.4.2 Biblical Assurances: Supporting Meaning-Making

With regards to the present findings pertaining to Biblical assurances, to the best of the present author's knowledge, this represents the first data in the psychological literature to lend support for the content of Biblical scripture being beneficial to coping and meaning-making in bereavement, or any other coping-related area. Essentially, Biblical scripture was used to support meaning-making processes by reaffirming the content of benevolent religious cognition. Participants were able to draw on a wide range of passages that reinforced beliefs about life after death; the resurrection; and God as a supportive, omniscient, omnipresent companion during times of suffering. As such, Biblical passages helped ameliorate symptoms of grief, such as feelings of loneliness or of being forsaken, and encouraged coping self-efficacy in the form of motivation and determination to cope. In addition, repetition of Biblical quotes or phrases was used to manage feelings of anxiety, fear, and depression.

Participants were able to use Biblical passages to find benefit in their loss by comparing their grief-related suffering with the suffering, and the significance of the suffering, of important Biblical characters (e.g. Jesus, the Virgin Mary) that changed how the bereaved perceived their own loss, as something that was less negative or manageable. In addition, the aesthetic qualities of the language and the conviction expressed in various passages (e.g. the Psalms) capturing a myriad of human emotions such as sadness, abandonment, and joy were particularly meaningful to the bereaved and helped to normalise participants' own fluctuating thoughts and feelings related to grief and efforts to cope. Similarly, Biblical scripture provided the bereaved with a literary and metaphoric language in which to make sense in a simpler way

the complex set of thoughts and emotions aroused by grief. For example, images or descriptions of darkness, crucifixion, or the cross were used as metaphors to express overlapping feelings of depression, despair, and hopelessness. Moreover, images and descriptions of light, goodness, and resurrection were used to represent positive emotions such as hope, optimism, and happiness; emotions that can be experienced in bereavement and are sometimes confusing to the bereaved as they seem out of context with the negative status of the loss.

4.4.3 Religious Ritual: Expression of Emotional Needs, and Emotion Regulation and Catharsis

Religious ritual was described in a number of ways as being helpful to coping with grief; however it is proposed that the process underlying the beneficial properties of religious ritual in coping was in religious ritual providing the bereaved with a way of expressing some of their emotional needs. This theory is most prevalent in the multiple ways religious ritual was described as being involved in maintaining or continuing a perceived emotional bond with the deceased, and is reflected in how participants often described this bond or link as a feeling of, or a desire for, "closeness". Indeed, within the attachment literature close proximity seeking is often seen as an expression of an emotional desire for protection and intimacy, while Kirkpatrick (2005) has written widely about religion in general providing emotional attachment needs (see section 2.6.2).

In addition, in the present study religious ritual was also described as being used to encourage emotion regulation and emotional catharsis; this latter process involves the ventilation or release of grief-related emotions. Religious rituals could be used as vehicles to stimulate the expression of sorrow and crying, and also to encourage positive emotions. The majority of participants found church services, and specifically the 14 Stations of the Cross, as particularly poignant in evoking emotion. Emotional catharsis is unsurprising considering the affectively charged content in hymns sung during services, and the emotional descriptions (and imagery) of suffering, death, and loss contained in depictions of the 14 Stations of the Cross (or The Passion), that can evoke pathos, sorrow, and remembrance of one's own loss through which cathartic release of grief may be achieved.

4.4.4 Spiritual Capital and Growth: Sense of Purpose, Meaning, and Religiosity

The role of religious belief and practice in identity change and sense of self following spousal bereavement is perhaps the most difficult aspect of religion and meaning reconstruction

to reconcile because religious influenced identity change lacks theoretical explanation. Therefore the present findings deserve some interpretation. In the present study, the influence of spiritual capital on identity change and sense of self seemed to be in increasing perceived meaningfulness and purpose to one's life, and increasing one's sense of confidence, responsibility, and independence. In addition, the present sample of participants at some level also perceived their own identity as someone who is religious, who is recognised as a Christian, or as an Anglican or Catholic. Therefore, the influence of spiritual capital and spiritual growth was also involved in relation to one's sense of religious identity. Indeed, following bereavement, the influence of spiritual growth was mainly to increase the sense of participant religiosity, and to increase participant self-perception as a Christian, as a religious member and parishioner, and as being pro-social. However, some caution should be taken in interpreting findings during interviews that endorse tendencies for pro-social behaviour because of the influence of self-presentation biases on the part of the participant.

4.4.5 Meaning Reconstruction

Although Christian belief and practice in the present study were related to the components of meaning reconstruction (i.e. sense making, benefit finding, and identity change), the findings do not fully support the entire meaning reconstruction model proposed by Gillies and Neimeyer (2006). The model in its entirety proposes that through sense making, benefit finding, and identity change, pre-loss meaning structures are reconstructed, including pre-loss meaning structures pertaining to religious/spiritual beliefs. However, nearly every participant in the present study articulated that their religious/spiritual pre-loss meaning structures, that is the content of their Christian beliefs prior to bereavement, had not changed, participants still believed in the same Christian concepts they believed in prior to their bereavement. The only reported change was not in content but in strength of their beliefs. The majority of participants in the present sample reported that their Christian beliefs had strengthened and that their religious practice had become more meaningful and profound, with engagement in some religious rituals such as prayer increasing.

One explanation for the lack of change in religious/spiritual pre-loss meaning structures is that these structures were able to assimilate the loss without any reconstruction or, in Piagetian terms, accommodation being needed. As such, the findings may fit more comfortably with models emphasising religion involved in positive re-appraisals of loss (e.g. Folkman, 2001; see section 1.12) whereby benevolent religious content can encourage benevolent re-

appraisals to be reached without any change in content of beliefs occurring. Therefore, the present findings suggest that the model of meaning reconstruction proposed by Gillies and Neimeyer (2006) may need to be modified so that sense making, benefit finding, and identity change can be engaged in without reconstruction being made to certain pre-loss meaning structures.

4.4.6 Future Research

The present study used an inductive approach to identify the underlying processes through which religion exerts a beneficial influence on coping. An application of this research is that future hypotheses may be generated from the findings and generalised to other domains of adult psychopathology and psychogerontology. For example, it could be examined how benevolent religious cognition, religious ritual associated emotion regulation, and identifying with Biblical characters of suffering, are involved in ameliorating depression, anxiety, and fear of death in older adults more generally. More specifically, it could also be examined how these processes influence psychological well-being and coping self-efficacy in those religious older adults caring for partners with dementia or Alzheimer's disease who may be prone to carer burnout.

A complementary study to the present research would be to identify what thought processes constitute benevolent *secular* cognition during coping and what non-religious literary material is beneficial to coping. For example, in the present study the book "A Grief Observed" by C. S. Lewis was mentioned as being helpful to coping and was also mentioned as helpful in the transcripts of an earlier bereavement study by Coleman et al. (2002, 2007). In addition, research should also identify the content of *malevolent religious cognition*; that is religious cognition that is unhelpful or harmful to coping and might be related to complicated or chronic grief (e.g. belief that God is vengeful; or perceiving one's bereavement as a punishment from God).

Finally, in the present study, although benevolent religious cognition, Biblical assurances, religious ritual, and spiritual capital were all described as being involved in coping, it remains unclear which of these religious dimensions may be the most salient in coping with bereavement, or which dimensions possess the biggest influence on coping. Therefore, future research should compare within the same statistical model the relative influence of these religious dimensions on coping with bereavement in older adults. Indeed, this will be a partial aim of Study 4 (see Chapter 6).

4.4.7 Summary

In summary, it is proposed that the present study allows the role of religion in bereavement and grief to be better understood. The content of benevolent religious cognition was involved in the meaning-making processes of sense making and benefit finding. Biblical assurances supported meaning-making by reinforcing the content of benevolent religious cognition, and encouraging coping self-efficacy. Religious rituals facilitated a way for the bereaved to physically express or regulate emotional needs for close proximity and to enhance a continuing bond with their deceased spouse, and encouraged emotional catharsis of grief-related emotion. Finally, spiritual capital encouraged positive post-bereavement identity change involving finding new purpose and meaning in life.

It will be interesting to see whether other researchers investigating different religions such as Islam and Judaism with their own religious rituals and religious scripture (the Qur'an and the Torah, respectively), will show similar patterns in coping with spousal bereavement to that articulated by Christian older adults in the present study.

PART 3

Chapter 5
The Importance of Religious Ritual Scale: Development, Validity, Reliability, and Factor Structure

5.1 Introduction

Influenced by the findings in Study 2 of the role played by religious ritual in coping and adjusting to spousal bereavement, we now go on to consider in more detail this aspect of religious practice. Study 3 and 4 aimed to examine further the relationship between religious ritual and coping with bereavement. In the absence of an adequate scale to measure religious ritual in the psychological literature and wider social sciences, the aim of Study 3 (present Chapter) was to develop the first psychological scale of its kind dedicated to measuring religious ritual. Study 4 (see Chapter 6) would then aim to use the scale alongside measures representing other religious dimensions in a study comparing salient religious and secular variables in predicting grief, depression, and anxiety in recently bereaved older adults.

Although religious ritual is highlighted as an important characteristic in definitions of religion and spirituality (e.g. King & Dein, 1998; Koenig, McCullough, & Larson, 2001; see section 2.2), surprisingly there is almost no empirical research on religious ritual. Indeed, of the more than 125 scales designed to measure the different dimensions of religion and spirituality, there does not appear to be one scale dedicated to measuring religious ritual (Hill & Hood, 2000; Pittard Payne, 1982). This fact is again surprising considering that some theorists have singled out ritual as being the essence and most important characteristic of religion (Alcorta & Sosis, 2005; Pilgrim, 1978; Spilka, 2005), and that religions may even originate from ritual performance, creating believers, and supporting belief throughout life (Alcorta & Sosis, 2005; Rappaport, 1999).

As highlighted by Spilka (2005), within the psychology of religion and spirituality as with the concept of religion itself, religious ritual has proven challenging to define, not least because of a lack of psychological research and theorising on religious ritual. Therefore, in order to understand and appreciate religious ritual at a deeper level before developing a religious ritual scale, it is first a good starting point to step back and examine the more general concept of *ritual* and what ritual is. From here there can be a gradual synthesis from the theorising of other disciplines and researchers, including psychologists, of an understanding and definition of religious ritual that can be used in psychological research.

5.1.1 Ritual

The ubiquity of ritual in the animal kingdom is well known to ethologists (Alcorta & Sosis, 2005; Rappaport, 1999), however it has also been suggested that ritual is universal in humans, appearing in all world cultures and religions (Grzymala-Moszczyńska & Simpson, 1997; Helman, 1994), and during important transitional stages of the life cycle (Boyer & Liénard, 2006). Although ritual has received scholarly attention in the humanities via theology, history, and philosophy, and in the social sciences through anthropologists and sociologists investigating various world cultures, traditions, and religions, within psychology ritual has been relatively neglected. This is perhaps surprising considering that early theorists whose ideas were influential in the development of contemporary psychology such as Durkheim, Freud, Erikson, Jung, and Lorenz all identified ritual as an interesting aspect of human behaviour and functioning.

Although ritual is difficult to easily define and definitions of ritual vary (Grimes, 2000), according to the theologian Susan White (2005) a basic definition that is generally agreed upon across anthropology, sociology, and religious studies is that ritual is a "culturally constructed system of symbolic communication, consisting of patterned repetitions of words and actions" (p.387; c.f. Tambiah, 1979). Interestingly, in the bereavement literature, the clinical psychologist Therese Rando (1985) similarly defines ritual as "specific behaviour or activity which gives symbolic expression to certain feelings and thoughts of the actor(s) individually or as a group" (p.236). Thus, although these definitions come from distinctly different disciplines of human enquiry, there is some definitional common ground or overlap (i.e. the use of repetitive behaviours/activities to symbolically express or communicate the meaningful thoughts, feelings, or values of an individual, group, or culture).

However, theorising on ritual by Grzymala-Moszczyńska and Simpson (1997) provides deeper insight into the concept of ritual, beyond mere definition, and offers a useful heuristic guide for approaching academic definitions of ritual and for understanding ritual more generally. According to Grzymala-Moszczyńska and Simpson (1997) a particularly interesting aspect of ritual is that it has a "multivalent" character. The full meaning of this term reflects that ritual has many applications and values however Grzymala-Moszczyńska and Simpson (1997) use it to focus on how ritual can operate, and thus importantly be interpreted, on more than one level simultaneously. Grzymala-Moszczyńska and Simpson (1997) suggest three fundamental levels that have been employed by theorists when interpreting ritual; these interpretations are at the level of *form*, *meaning*, and *purpose*.

The level of *form* refers to interpretations that focus on the most obvious and apparent characteristics of ritual, usually the visible behavioural and aesthetic components. Definitions and descriptions at this level often emphasise some of the following: that rituals involve activities or behaviours that have a prescribed structure, pattern, order, or sequence, and that these behaviours are performed repetitively and with little variation (Grimes, 2000; Rappaport, 1999, Spilka, 2006; White, 2006); that rituals can be performed as part of a group or individually (Castle & Philips, 2003; White, 2006); that rituals can be engaged in habitually or on one occasion (Castle & Philips, 2003; Rando, 1985); and that rituals can involve categories of role, for example orchestrators, participants/performers, and onlookers.

The level of *meaning* refers to interpretations that focus on the underlying rationale or reason for a ritual, to what a ritual signifies, and can include details about a ritual's semantic content. The level of meaning may be the most difficult level for an outsider to the ritual to fully understand or appreciate. Definitions and descriptions at this level often emphasise a ritual as occurring within a specific context, as being secular or sacred, as being part of a long tradition or newly created, as being performed for reasons important to a group or for subjective reasons, and as varying in level of formality (Castle & Philips, 2003). At this level a ritual is often described as being a symbolic enactment (Davis-Floyd, 1992), expressing something more latent and tacit that would be difficult to capture or express in exactly the same way through words or thoughts alone (White, 2006).

Finally, the level of *purpose* refers to interpretations that focus on the function or role that a ritual plays for an individual or group, and sometimes speaks of an end goal to a ritual. At this level the researcher, being an outsider and approaching the ritual from a different perspective, may be aware of things the ritual performers themselves may be unaware of. Definitions and descriptions at this level can focus at both the micro and macro scale, for example from rituals that govern social interactions to rituals commemorating important events in a group's history (White, 2006). At the level of purpose rituals are often described as creating a sense of group solidarity or community, or as maintaining the status quo of a group (Grimes, 2000; Spilka, 2005) through processes such as channelling the emotions at individual or group levels (Spilka, 2005). A recurrent theme in the ritual literature is that rituals have a transformational purpose and are used to help a person move from one phase of their life or identity to a new one (Romanoff & Terenzio, 1998). Rituals of transformation may include initiations, inductions, and rites of passage.

Thus, according to Grzymala-Moszczyńska and Simpson (1997), depending on the academic discipline or proclivity of the researcher for depth of analysis, as an initial starting point for examining ritual certain elements may be primarily emphasised or foregrounded, thus creating differences in definitions and interpretations. Interestingly, based on this theory Grzymala-Moszczyńska and Simpson (1997) provide discussion that could be used as evidence to partially explain psychology's reluctance to empirically examine ritual. Grzymala-Moszczyńska and Simpson (1997) discuss how Freud and the early psychoanalysts who followed him, when analysing religious ritual predominantly focused only at the level of form and proceeded to draw similarities with the ritual form observed in neuroticism. Grzymala-Moszczyńska and Simpson (1997) argue that Freud and other psychoanalysts neglected or minimised the meaning underlying religious ritual and subsequently coloured religious ritual as pathological, establishing a precedence and influencing those who would follow.

5.1.2 Religious Ritual

The demarcation between religious practice and religious ritual, and what activities are considered religious rituals, has not been clearly addressed or discussed in the psychology of religion literature. This leaves some room for theoretical exploration.

A narrow approach to conceptualising religious ritual comes from Lawson and McCauley (2002a, 2002b) who approach religious ritual from a philosophical/cognitive science of religion perspective. For these theorists, the term religious ritual is reserved only for religious ceremonies in which an agent (e.g. an ordained priest) engages in an action on someone (a ritual participant) or something (an instrument to be used) in order to bring about a temporary or permanent religious change. Thus according to this theory's technical sense only ceremonies such as ordinations, baptisms, weddings and so on would be considered as religious rituals. Activities such as prayer, genuflecting, singing, chanting, that other theorists have referred to as rituals would not be included. Thus, for Lawson and McCauley (2002a, 2002b) as long as a religious ritual is conducted by a legitimate religious agent or representative, the religious ritual changes the perceived religious identity of the ritual participant in the eyes of others in accordance with the ritual conducted, and unlike private rituals such as prayer, this process cannot be faked (McCauley & Lawson, 2008).

A broader and more encompassing approach is from Bernard Spilka (2005), a long term pioneer in the psychology of religion, who suggests that religious ritual is essentially the behavioural practice of one's faith. Indeed, there is some support for this approach from the

theologian Susan White (2006) who in discussing ritual in the context of Christian spirituality has suggested that religious ritual can involve worship activities ranging from the least formal to the most formal. Thus, based on this broader approach, inspection of the psychology of religion and spirituality literature reveals that many religious behaviours and activities have been labelled, and can certainly be considered, religious rituals. Some prominent Christian examples include: prayer and ceremony (Spilka, 2005); pilgrimages and festivals (Grimes, 2000; Morris, 1982; Pargament, 1997); genuflecting, knelling, bowing, and prostrating (Alcorta & Sosis, 2005; Pargament, 1997; Spilka, Hood, Hunsberger, & Gorsuch, 2003); singing, chanting, and dancing (Alcorta & Sosis, 2005); reading religious scripture (Koenig, McCullough, & Larson, 2001; Pargament, 1997); attending Holy Communion/Eucharist (Hinde, 1999; Wulff, 1997); confession (Jacobs, 1992; Murray-Swank, McConnell, & Pargament, 2007; Pargament, 1997); fasting (Jacobs, 1992; Spilka, 2005); religious rites of passage (Alcorta & Sosis, 2005; Pargament, 1997); reciting the rosary and meditation (Anastasi & Newberg, 2008); sacrifice (Hinde, 1999); and worship on annual holy days (Spilka, 2005; White, 2006).

Thus, based on the theorising of Spilka (2005), religious ritual can be considered to describe the specific activities and behaviours that make up the broader concept of religious practice. In other words, when religious members engage in religious practice, they do so using religious rituals. In addition, although Spilka's (2005) conceptualisation places emphasis on the behavioural component of religious ritual, it is very apparent from the theorising of others (e.g. Alcorta & Sosis, 2005; Jacobs, 1992; Pargament, 1997) and from interviews with religious members, that religious rituals equally involve cognitive and emotional processes. For example, prayer involves specific cognitive activity (e.g. thoughts, concentration, inner dialogue), and ceremonies encourage contemplation and remembrance, while most religious rituals have specific theological or religious meanings, and nearly all rituals will elicit a range of emotions.

5.1.3 What Makes Religious Ritual Distinctive

In thinking about what makes religious rituals distinctive from secular activities or rituals it is useful to turn to the detailed writing on religious ritual by Lawson and McCauley (2002a, 2002b). Although their theorising is discussed mainly in the context of ceremonial religious rituals, many of the principles and much of the theorising can be applied to the broader concept of religious ritual as used here more generally.

According to Lawson and McCauley (2002a, 2002b) a primary feature that marks religious rituals as distinctive from other activities is a unique reference group (Spilka, 2005) labelled culturally postulated superhuman (CPS) agents. These CPS agents are considered unique and differ from human agents because they possess what Lawson and McCauley (2002a, 2002b) call "special counter intuitive properties", and depending on the religious system may refer to, for example, notions of a God or Gods, Christ, Saints, or ancestors. Furthermore, equally as important as the concept of this transcendent reference group is the perception of the role played by CPS agents in religious rituals. Religious members are suggested to engage in religious rituals with the belief that CPS agents themselves at some level also have the ability or potential to act. Thus the different perceptions of the roles played by CPS agents in religious rituals contribute toward giving religious rituals their unique properties, and may well have been influential in shaping the structural form of many rituals themselves. Thus the perception of the role of CPS agents in religious rituals of consecration or initiation may well differ from the perception of the roles of CPS agents in rituals of intercession or remembrance.

A related distinctive feature of religious rituals is that unlike non-religious rituals that potentially could have a myriad of ways of concluding, from the perspective of religious members once direct appeals or invocations have been made all religious rituals end with presumptions about the responses or actions of the CPS agents. Presumptions that according to Lawson and McCauley (2002b) require little further cognitive explanation or justification.

In addition, there may also be issues related to the perceived legitimacy, validity, and effectiveness of a religious ritual that are unique to religious practices. From the standpoint of religious members, in order for a religious ritual to be perceived as legitimate and effective it is usually necessary that elements of the ritual be perceived as being somehow connected directly or indirectly to a CPS agent. This connection can be created during the ritual being carried out or in a previous religious ritual. So, for example, a religious minister will need to have been ordained in a previous religious ritual in order to conduct a marriage or baptism, while if certain instruments are used such as water or bread and wine they will also need to have been consecrated in an earlier religious ritual. Thus, these earlier rituals that Lawson and McCauley (2002b) refer to as "enabling rituals" help to connect the ritual being conducted to the CPS agent and which in turn facilitates the perception of the religious ritual's legitimacy and effectiveness. If the religious ritual is perceived as not having a connection with a CPS agent,

or if the connection is impaired through incorrect ritual form or execution, religious members may perceive the ritual as illegitimate, invalid, or ineffective.

Thus, based on the theorising of Lawson and McCauley (2002a, 2002b) religious rituals are distinguishable from other activities because from the perspective of religious members, CPS agents are always somehow involved in religious rituals. This involvement may be perceived or experienced directly as in the case of the Eucharist or Holy Communion, through human intermediary agents initiating rituals, through earlier enabling rituals, or through the consecrated instruments used. Additional criteria such as the location or time when the religious ritual is conducted may also become important.

A further distinction is what Lawson and McCauley (2002a, 2002b) refer to as the "insider-outsider criterion". This principle simply refers to the observation that usually it is only those who have been initiated as members within a religious system who are permitted to engage in religious rituals. So, for instance, an elaboration on the example used by Lawson and McCauley (2002a, 2002b) is that although a non-Catholic may be allowed to attend a Holy Communion service they will usually not be permitted to receive the Blessed Sacrament.

Related to this criterion is that for insider or ingroup religious members, engagement in religious ritual norms will often be taken as a sign of adherence and commitment to the religious group's values and to the religious system, while if religious members fail to adhere to ritual norms there may be penalties (White, 2005). Furthermore, if ritual participants or potential participants are not perceived as possessing the requisite qualities for a religious ritual again the ritual may be perceived as being ineffective, inappropriate, or of sacrilege being committed.

Thus, theorising that suggests connections to CPS agents as a characteristic distinguishing religious rituals from non-religious, is similar to the theorising of Pargament (1997) that suggests connections to the sacred distinguish religion from the mundane. Indeed, Alcorta and Sosis (2005) have stated that "religious ritual is universally used to define the sacred and to separate it from the profane" (p.332). Furthermore, Spilka (2005) suggests that religious ritual involves reification, that is the making of something abstract more concrete or real. Thus, from these different theorists it seems that religious ritual is important in both defining the sacred and bringing religion to life.

5.1.4 Form, Meaning, and Purpose of Religious Ritual

Applying the guide provided by Grzymala-Moszczyńska and Simpson (1997) to religious ritual offers further insights. At the level of *form*, as highlighted by Lawson and McCauley (2002a, 2002b), religious rituals in themselves are quite distinctive. People generally recognise a religious ritual by its form when they witness one. Many of the characteristics are similar to non-religious rituals (see above) with perhaps particular significance placed on specific symbols, objects, artefacts, relics, icons, instruments, vestments, vocalisations, and use of music (Alcorta & Sosis, 2005; Hinde, 1999).

However, it is at the level of *meaning* that religious rituals may be at their most unique. Religious rituals are usually conducted in the context of a detailed belief system which may prescribe a rationale and rules for their performance. Religious rituals are often part of a long tradition and history and perceived as being authorised by God (White, 2006), and used as a way to demonstrate religious commitment and observance. Furthermore, through repeated ritual performance, religious members may come to invest rituals or components of rituals such as symbols and objects with extra emotional or cognitive meaning, sometimes of a personal nature, in addition to their religious significance (Alcorta & Sosis, 2005; Hinde, 1999). This process may subsequently prime emotions just by the very thought of the ritual. In addition, religious members may come to project religious meanings on to members of the clergy conducting rituals, and perceiving them as more than just religious intermediaries but as individuals possessing sacred qualities.

At the level of *purpose*, the literature on religious ritual suggests a myriad of potential purposes, functions, and benefits. However, as highlighted by Spilka (2005) perhaps the primary purpose of religious ritual is to help religious members "contact, identify with, and/or influence" (p.367) God or whatever is considered sacred. This observation is supported by other theorists who use similar terms such as relationship, interaction, transaction, and communication to describe the bringing together of humans and the sacred through religious rituals (e.g. Grimes, 2000; Honko, 1979; Lawson & McCauley, 2002a, 2002b; White, 2006).

A number of theorists have also suggested in various ways that an important purpose of religious ritual is to facilitate healthy relationships with others and also with oneself (Grzymala-Moszczyńska & Simpson, 1997; Spilka, 2005; White, 2006). Furthermore, Spilka (2005) highlights how religious rituals can be used to stimulate a range of positive thoughts and emotions, for example feelings of comfort, support, and protection; feelings of control over oneself and one's personal world; and feelings of renewal and rebirth. In addition, religious

rituals can be used to atone for possible sins committed and to reinforce or reaffirm one's belief (Hinde, 1999; Spilka, 2005). Indeed, as a result of these many functions, as Grzymala-Moszczyńska and Simpson (1997) point out, religious ritual has come to the attention of theorists interested in coping, as a potential coping resource (e.g. Pargament, 1997).

5.1.5 Therapeutic Properties

Jacobs (1992) discusses two related therapeutic benefits that can potentially be experienced through religious rituals, namely, emotional catharsis and anxiety reduction. Jacobs (1992) describes how religious rituals can provide conditions for the acknowledgment, expression, and resolution of negative emotions such as shame, guilt, anger, sorrow, and grief. Jacobs (1992) suggests that through engagement in religious rituals such as prayer, attending church services, and confession, religious members experience a reinforcement of the attachment or connection with whatever they consider sacred or holy (e.g. God, a religious minister, a specific group, a significant other person). This interpersonal feeling of connection then facilitates the conscious retrieval of the source of negativity, and the unpleasant or negative emotions evoked are worked through or resolved during the execution of the religious ritual in the context of worship (Jacobs, 1992).

Related to this cathartic process is an accompanying reduction in anxiety through the perception of unburdening unpleasant thoughts or emotions in an interpersonal relationship that is considered sacred. Moreover, in the context of confession the unburdening of wrong doings or transgressions brings forgiveness and a sense of absolution (Jacobs, 1992). Thus, the cathartic process experienced through religious rituals is considered therapeutic as the externalization of negative thoughts or emotions prevents them from being internalized back against the self where they may do more harm (Jacobs, 1992).

Interestingly, several theorists have suggested that religious rituals can reduce anxiety, primarily through the ability of rituals to reduce uncertainty, ambiguity, or ambivalence (Hinde, 1999; Spilka, 2005). Indeed, White (2006) suggests that people can develop a sense of trust and certainty through ritual performance. Recent support for religious ritual's effect on reducing anxiety comes from Anastasi and Newberg (2008) who found that participants who in an intervention task recited the rosary showed lower levels of state anxiety compared with a second group who watched a religious content film. Furthermore, in an earlier longitudinal study, Morris (1982) found a decline in anxiety and depression for up to ten months in physically ill men and women who went on a pilgrimage to Lourdes.

In another line of investigation, research has repeatedly demonstrated that church attendance is associated with a range of health benefits, for example lower hypertension (Koenig, George, Cohen, Hays, Blazer, & Larson, 1998b), improved immune system functioning (Koenig, Cohen, George, Hays, Larson, & Blazer, 1997), and lower risk of early mortality (Hummer, Rogers, Nam, & Ellison, 1999). Although the salutary health effects are often attributed to church attendance demonstrating commitment to a belief system, and the belief system encouraging healthy lifestyle practices, an alternative interpretation is that church attendance offers access to religious rituals, and it is these more specific behaviours that impact on health and wellbeing. With the availability of a scale to measure religious ritual, future research will be able to examine the effects of both attendance and religious ritual.

5.1.6 The Present Study

The aim of the present study is to develop and provide preliminary psychometric properties for a scale to measure religious ritual in the context of Christianity. More specifically, the scale will be designed to measure attitudes towards the importance of widely endorsed Christian religious rituals.

As a starting point to approaching religious ritual, where so little is known empirically, a broad approach will be taken. Thus, for the purposes of the present study religious ritual will be considered to refer to the activities and behaviours that guide, facilitate, and circumscribe general religious practice (Spilka, Hood, Hunsberger, & Gorsuch, 2003). This approach will include Christian rituals that are performed repetitively or on one occasion, that are performed privately or in public, and that may be performed individually or communally. A broad approach is considered optimal as it will allow future researchers to further refine what is included within the category of religious ritual, and to examine at a more specific level what religious rituals have certain links with mental and physical health.

5.2 Method

5.2.1 Participants

The study used a self-selective, opportunity sample of 254 older adults recruited through the School of Psychology older adult research participation pool and through posters placed in local community centres and churches. The mean age of participants was 71 years, (SD) = 8.3 years, with an age range of 55 to 91 years. There were 181 (71.3%) females and 73 (28.7%) males.

A total of 221 (87%) participants agreed to take part in the follow-up component one month later, 31 (12.2%) declined, and 2 (0.8%) did not indicate. Of the 221 participants who did agree, 213 (96.3%) completed the Importance of Religious Ritual Scale on two separate occasions, 154 (72.3%) were female and 59 (27.7%) were male, with a mean age of 71 years (SD) = 8 years.

A sample size estimation was made based on several guides to conducting factor analysis (e.g. Brace, Kemp, & Snelgar, 2006; Field, 2005; Pallant, 2005) and in line with factor analysis convention to ensure a ratio of more than five participants per item on the scale to be factor analysed.

5.2.1.1 Sample Religious Characteristics

Table 9 shows that approximately 70% of participants indicated having a religious or spiritual understanding of their life, with the majority (33.2%) considering this understanding as being both religious and spiritual. Almost 40% of participants indicated attending religious services up to once a month, with over half the sample (52.2%) indicating having some experience of attending religious services with some degree of regularity. Of those participants who did endorse attending religious services, the majority indicated attending on a weekly basis (23.7%). Over 61% of participants indicated some experience of engaging in prayer, with over 30% of participants saying that they prayed on a daily basis.

Table 9.

Number of participants, percentages, and cumulative percentages for religious/spiritual understanding of life, frequency of attendance at religious services, and frequency of prayer.

	N	%	Cumulative %
RELIGIOUS/SPIRITUAL UNDERSTANDING			
Religious	52	20.6%	20.6%
Spiritual	41	16.2%	36.8%
Religious and Spiritual	84	33.2%	70%
Neither Religious nor spiritual	76	30%	100%
FREQUENCY OF ATTENDANCE AT RELIGIOUS SERVICES			
More than once a week	18	7.1%	7.1%
At least weekly	60	23.7%	30.8%
At least monthly	18	7.1%	37.9%
Less often	36	14.3%	52.2%
Rarely or never	121	47.8%	100%
FREQUENCY OF PRAYER			
Daily	77	30.4%	30.4%
More than once a week	18	7.1%	37.5%
At least weekly	21	8.4%	45.9%
At least monthly	17	6.7%	52.6%
Less often	23	9.1%	61.7%
Rarely or never	97	38.3%	100%

Table 10 shows that approximately 73.6% of participants indicated belonging to or identifying with some kind of religious or spiritual denomination, with approximately 72.8% indicating membership specifically to a Christian denomination. Over 50% of participants indicated their denomination as being Church of England, 11% indicated Roman Catholic, and a further 11% were spread across a range of Christian denominations. Approximately 20.8% of participants indicated that they did not observe a religion.

Table 10.

Number of participants, percentages, and cumulative percentages for religious/spiritual denominational characteristics of the sample

	N	%	Cumulative %
Church of England/Anglican	129	50.8%	50.8%
Roman Catholic	28	11%	61.8%
Methodist	8	3.1%	64.9%
Quaker	7	2.7%	67.6%
Baptist	3	1.2%	68.8%
Non-Conformist Christian	2	0.8%	69.6%
Church of Scotland	2	0.8%	70.4%
Salvation Army	1	0.4%	70.8%
United Reform Church	1	0.4%	71.2%
Protestant	1	0.4%	71.6%
Christian Spiritualist	1	0.4%	72%
Evangelical Christian	1	0.4%	72.4%
Non-Denominational Free Church	1	0.4%	72.8%
Pagan	1	0.4%	73.2%
Buddhism	1	0.4%	73.6%
I do not observe a religion	53	20.8%	94.4%
Humanist	5	2%	96.4%
Atheist	4	1.6%	98%
Agnostic	2	0.8%	98.8%
Other	2	0.8%	99.6%
Missing	1	0.4%	100%

5.2.1.2 Sample Bereavement Characteristics

In the present sample, 74 (29.1%) participants, 65 females and 9 males, reported experiencing bereavement from a spouse. The mean age of these bereaved older adults was 75.9 years (SD = 7.9 years). Table 11 shows that the mean length of time married for these bereaved participants was 34.7 years, with the mean age of experiencing spousal bereavement

being 61.9 years. The mean time since bereavement was 13.9 years with a range of 10 months to 37 years.

Table 11.

Means, standard deviations, and age ranges for number of years married, participant age at time of bereavement, and time since bereavement.

	M	SD	Range
Length of time married	34.7 years	13.9 years	2 - 58 years
Age at time of bereavement	61.9 years	11.9 years	34 - 82 years
Time since bereavement	13.9 years	8.1 years	10 months –37 years

Table 12 shows that the sample had experienced both anticipated and sudden bereavements, although slightly more participants had experienced an anticipated or expected bereavement preceded by a chronic illness (53%) than a sudden or unexpected bereavement (47%). Table 12 also shows that the sample varied in the causes of death of participants' spouses. The most frequent cause of death was as a result of heart or lung conditions (36%) and was closely followed by deaths caused by a specific type of cancer (33%). The next most frequent cause of death was organ or multiple organ failure (9%). Causes of death as a result of a degenerative neurological disease and from a cerebral tumour or disease together accounted for about 12%. Other causes of death included traffic accidents, diabetes, and alcoholism.

Table 12.

Number of participants and percentage of sample for level of bereavement forewarning and causes of bereavement.

	N	%
FOREWARNING		
Expected (chronic illness, months/years)	39	53%
Sudden (no forewarning or hours/days)	35	47%
CAUSES		
Heart or lung conditions (e.g. pneumonia, heart attack)	26	36%
A form of cancer (including leukaemia)	24	33%
Organ or multiple organ failure	7	9%
Degenerative neurological disease (e.g. dementia, Alzheimer's)	5	7%
Cerebral tumour or disease (e.g. stroke, brain tumour)	4	5%
Traffic accident	4	5%
Diabetes	2	3%
Alcoholism	1	1%
Missing	1	1%

5.2.1.3 Sample Socio-demographic Characteristics

Table 13 shows that slightly more of the sample was married (52.8%) than not married (46.8%), and that the majority of participants were white (98.4%). The sample contained a range of educational backgrounds, and most participants reported that they were now retired (82.7%). The majority of participants reported their perception of their financial situation as good (54.3%).

Table 13.

Number of participants and percentages for socio-demographic details of the sample.

	N	%
MARRIED		
Yes	134	52.8%
No	119	46.8%
Missing	1	0.4%
ETHNICITY		
White	250	98.4%
Other	2	0.8%
Missing	2	0.8%
EDUCATION		
School	94	37%
College	75	29.5%
University	49	19.3%
Postgraduate	34	13.4%
Missing	2	0.8%
EMPLOYMENT STATUS		
Employed full time	10	3.9%
Employed part time	29	11.4%
Unemployed	4	1.6%
Retired	210	82.7%
Missing	1	0.4%
PERCEPTION OF FINANCIAL SITUATION		
Excellent	10	3.9%
Very good	43	16.9%
Good	138	54.3%
Fair	52	20.5%
Poor	8	3.1%
Missing	3	1.2%

5.2.2 Design

A large scale, cross-sectional postal survey design was used in order to examine the validity, internal consistency reliability, and factor structure of the newly developed Importance of Religious Ritual Scale. The Importance of Religious Ritual Scale was embedded within a broader study examining religious belief and practice, health, quality of life, and life satisfaction in British older adults. The survey design also included a follow-up component to establish temporal test-retest reliability for the Importance of Religious Ritual Scale over a one month period. For the follow-up component the Importance of Religious Ritual Scale was completed by itself.

5.2.3 Materials and Apparatus

An information/consent form (see Appendix O) and debriefing form (see Appendix P) were provided to all participants. The debriefing form contained the additional information of the contact details for "Cruse" a national bereavement organisation. This information was included in case there were any participants who may have experienced bereavement who wanted to discuss or seek out further information related to their experience.

All questionnaire instruments were selected based on their established validity and reliability, and where possible for their use in previous research with older adults.

5.2.3.1 Socio-Demographic Information

A socio-demographic questionnaire (see Appendix Q) was created to measure a number of socio-demographic variables that would help to contextualise findings and were considered to be important in religion, health, and quality of life research with older adults. These variables included: age, gender, ethnicity, marital status, level of education, employment status, perception of one's financial situation, and whether the participant had ever experienced bereavement from a spouse or partner. For participants who answered affirmatively to this latter question there were four additional items investigating: how long ago the spouse or partner passed away; length of marriage to the deceased spouse; level of bereavement forewarning; and the cause of death of the spouse or partner. The response format for socio-demographic items ranged from dichotomous responses (e.g. male/female, yes/no); multi-item responses (e.g. from excellent to poor); and free/open responses (e.g. age).

5.2.3.2 Religious and Spiritual Belief

The Royal Free Interview for Spiritual and Religious Beliefs (King, Speck, & Thomas, 2001; see Appendix F) was used to measure strength of religious and spiritual belief. (See section 3.2.3.4 for a description of the scale and for details about the scale's psychometric properties).

5.2.3.3 Importance of Religious Ritual Scale

The results section (see section 5.3) details the items, validity, reliability, and underlying factor structure of this newly developed questionnaire.

5.2.3.4 Ritualism: Attitudes and Responses to Religious Ritual

The ritualism subscale of Maranell's (1974) multidimensional scale of religious attitudes and religiosity was used to measure attitudes and responses toward religious ritual (see Appendix R). The subscale focuses mainly on the ceremony of formal worship and contains 12 items that measure various aspects of one's attitude toward ritual that include an individual's aesthetic appreciation of religious services; attitudes about the structure, formality, and standards of liturgy; and the personal meaning and importance of ritual worship for the individual. Items are scored along a five point Likert response format ranging from 0 (strongly disagree) to 4 (strongly agree). Item scores are summed to give an overall total ranging between 0 and 48, with higher scores indicating increased appreciation of ritualism or ritualistic behaviour in religious worship.

In his book long work detailing his multidimensional scale, Maranell (1974) provided support for the content and construct validity of the ritualism subscale including comparing ritualism scores across multiple Christian religious denominations and with non-religious samples, and also in item sensitivity analysis in high and low criterion groups. Furthermore, Maranell (1974) reported test-retest reliabilities ranging from 0.87 to 0.89 over an interval of one to one-and-a-half-weeks. Recent research by Dorahy and Lewis (2001) using United Kingdom samples including an older Catholic sample (M = 50.6 years) has further supported the validity of the ritualism subscale as a measure of religious ritual.

5.2.3.5 Brief Multidimensional Measure of Religiousness/Spirituality

Public religious practice, private religious practice, religious/spiritual coping, and religious forgiveness were all taken from the subscales of the Brief Multidimensional Measure

of Religiousness/Spirituality (BMMRS; Fetzer/NIA, 1999; see Appendix S). The BMMRS was developed by an expert panel of researchers working within the areas of religion/spirituality, health, and ageing, and designed to capture the multiple dimensions of religion and spirituality likely to be linked to health variables and relevant in ageing research. The BMMRS contains 38 items across 12 subscale dimensions. In a large scale population based survey that included older adults, Idler et al. (2003) reported that the scale had good construct validity and internal consistency reliabilities ranging from 0.54 to 0.91 across subscales.

Public Religious Practice was used to measure level of involvement in a formal public religious institution or organization, through which access to formal religious rituals could be gained (Idler et al. 2003). The subsection contains two items measured on a six point response format ranging from 1 (more than once a week) to 6 (never). Scores were reversed and summed, with higher scores indicating greater involvement in public or organizational religious practice. In a recent study with a sample that included older adults, Johnstone, Yoon, Franklin, Schopp, and Hinkebein (2009) reported an alpha reliability of 0.73.

Private Religious Practice was used to measure level of engagement in religious activities or behaviours that takes place outside of a formal religious institution and are performed regularly either alone or with family. This subsection contains five items; four are measured on an eight point response format ranging from 1 (greatest frequency) to 8 (never), and one item measured on a five point format, ranging from 1 (greatest frequency) to 5 (never). Scores were reversed and summed, with higher scores indicating greater engagement in private religious behaviours or activities. In a recent study using older adults, Yoon (2006) and Yoon and Lee (2004) reported a Cronbach's alpha level of 0.72.

Religious/Spiritual Coping was used to measure the degree to which an individual's religious or spiritual belief is used in coping with major problems in life. The subsection contains seven items (three items measuring positive strategies, two measuring negative strategies, and two measuring general use of religion in coping). The subsection uses a four point response format ranging from 1 (a great deal) to 4 (not at all). Scores were reversed and summed, with higher scores indicating greater involvement of religious or spiritual belief in coping. In a recent study using older adults, Yoon (2006) and Yoon and Lee (2004) reported a Cronbach's alpha level of 0.81.

Religious Forgiveness was used to measure the degree to which an individual's religious or spiritual belief influenced forgiveness of oneself and others, and of a belief in a forgiving God. The subsection contains three items measured on a four point response format

ranging from 1 (always or almost always) to 4 (never). Scores were reversed and summed, with higher scores indicating greater degree of religious/spiritual belief related forgiveness. In a recent study using older adults, Yoon (2006) and Yoon and Lee (2004) reported a Cronbach's alpha level of 0.64.

5.2.3.6 Global Health Status

The Short-Form 36-item (SF-36) Health Survey (Ware & Sherbourne, 1992; see Appendix T) was used to measure general heath status. The SF-36 is a 36 item scale that uses a multi-item format to measure eight dimensions of health status: 1) Physical functioning; 2) Role limitations due to physical problems; 3) Role limitations due to emotional problems; 4) Social functioning; 5) Bodily pain; 6) Mental health; 7) Vitality and energy; and 8) General health perception. The SF-36 also contains an additional categorical measure to assess perceived change in health status over a one year period. For each of the eight dimensions item responses are summed and transformed to form an overall score for each dimension. Scores range from 0 (worst possible health) to 100 (best possible health).

According to a review by Haywood, Garratt, and Fitzpatrick (2005) of health instruments used in research with older adults, the SF-36 has good evidence of validity and reliability and has been evaluated with older adults in up to 72 international studies including 20 in the UK. In one particular study of British community dwelling older adults (aged >65 years), Walters, Munro, and Brazier (2001) supported the construct validity of the SF-36 and reported internal consistency reliability using Cronbach's alpha of greater than 0.79 for all eight dimensions. As such, Haywood et al. (2005) recommended the use of the SF-36 to assess health status in community dwelling older adults, while Walters et al. (2001) concluded that the SF-36 was well-suited for use in postal surveys with older adults.

5.2.3.7 Quality of Life

The EUROHIS-QOL 8-item index (Schmidt, Mühlan, & Power, 2005; see Appendix U) was used to measure quality of life. This scale is a short form measure of quality of life and is derived from the WHOQOL-100 and WHOQOL-BREF. The scale consists of eight items and measures quality of life in four different domains (i.e. psychological, physical, social, environmental), with two items representing each domain. Each item is measured on a 5 point Likert response format ranging from, for example, 1 (very dissatisfied) to 5 (very satisfied) and scores are summed to give an overall total. Higher scores indicate better quality of life. In a

recent large scale cross cultural study involving ten European countries, Schmidt et al. (2005) provided support for the scale's psychometric properties including underlying factor structure and convergent and discriminant validity. Schmidt et al. (2005) also reported an internal consistency reliability of 0.83 in UK and European samples that included older adults.

5.2.3.8 Life Satisfaction

The Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985; see Appendix V) was used to measure global life satisfaction. The SWLS consists of 5 items each requiring the participant to make an overall cognitive-judgement on their life satisfaction based on criteria or standards important to the individual (e.g. In most ways my life is close to my ideal). The scale uses a seven point response format for each item ranging from 1 (strongly disagree) to 7 (strongly agree). Scores for each of the items are summed to give one overall total score ranging from 5 (low satisfaction with life) to 35 (high satisfaction with life). The SWLS is a widely used measure of life satisfaction and has been frequently used in studies with older adults (e.g. Cappeliez & O'Rourke, 2006; O'Rourke, 2004). Diener et al. (1985) provide support that the scale has good psychometric properties including a single underlying factor structure, internal consistency reliability of 0.87, and test-retest reliability of 0.82 over two months. Using an older adult sample, Pavot, Diener, Colvin, and Sandvik (1991) demonstrated that the scale had good convergent validity with other measures of satisfaction and well-being, and had an internal consistency reliability of 0.83. More recently, Elavsky et al. (2005) reported internal consistency reliabilities of greater than 0.85 with older adults.

5.2.3.9 Social Desirability Bias

The Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1984, 1991; see Appendix W) was used to measure two types of social desirability bias. The BIDR is a commonly used measure of socially desirable responding and conceptualises this bias as being composed of two separate but related factors, namely: self-deceptive enhancement (SDE) and impression management (IM). Paulhus (1991) defined SDE as "the tendency to give self-reports that are honest but positively biased" (p.37) and defined IM as "deliberate self-presentation to an audience" (p.37). The BIDR consists of 40 items overall, 20 items representing the SDE subsection and 20 representing the IM subsection. Items take the form of propositions that participants have to rate their level of agreement with along a 7 point Likert response format ranging from 1 (not true) to 7 (very true). Once the negatively worded items

have been reversed, scoring involves assigning a 1 to every extreme answer (6 or 7) and the rest with a zero, and then summing items to form two total scores, one for the SDE subsection and one for the IM subsection. Thus, for each subsection or factor, scores can range between 0 and 20, with higher scores indicating greater social desirability bias in responding to statements. Paulhus (1991) has provided support for the convergent and divergent validity of both SDE and IM, and reported internal consistency reliabilities ranging between 0.68 and 0.80 for SDE and between 0.75 and 0.86 for IM. Both the SDE and IM subsections have been used in studies with older adults (e.g. O'Rourke, 2004; O'Rourke & Cappeliez, 2002).

5.2.3.10 Agreement to Complete Follow-Up Component

Toward the end of the questionnaire booklet a brief question appeared asking participants if they would be willing to complete one of the previous questionnaire instruments again in one month's time. Participants simply ticked one of two boxes (yes/no) indicating their willingness.

5.2.3.11 Overall Questionnaire Booklet

The individual questionnaire instruments were organised into a 19 page booklet that could be easily posted to participants. On the front page of the booklet were brief instructions for completing the booklet, with the information/consent form appearing on the first inside page. The completion order was standardised for all participants with the more salient and demanding questionnaire instruments appearing early in the booklet and the less salient and less demanding appearing towards the end. This strategy was used in order to counter against any fatigue or boredom effects on the part of the participant during questionnaire completion affecting results on the Importance of Religious Ritual Scale.

The booklet had 13 sections with each section presenting a new questionnaire instrument. The questionnaire order of appearance in the booklet was as follows: 1) Socio-demographic information; 2) The Royal Free Interview for Spiritual and Religious Beliefs; 3) The Importance of Religious Ritual Scale; 4) Maranell's (1974) Ritualism Attitude Dimension; 5) Public Religious Practice; 6) Private Religious Practice; 7) Religious/Spiritual Coping; 8) Religious Forgiveness; 9) Global health (SF-36); 10) Quality of life; 11) Life satisfaction; 12) Social desirability; 13) Participant agreement to complete the follow-up component. The debriefing statement appeared on the final page of the booklet.

Unique instructions for completing each questionnaire instrument appeared at the start of each new section. In developing the questionnaire booklet, every attempt was made to keep the booklet sections as logical as possible with regard to grouping related scales together, as concise as possible by using short form measures where available, and by keeping the questionnaire as easy to understand as possible while simultaneously maintaining its ability to acquire as much information as possible.

5.2.3.12 Pilot Study

A pilot study of 10 older adults (M = 70.5 years, 7 females, 3 males) known to the researcher were used to test run the questionnaire booklet and to investigate the time taken to complete the booklet, the wording of questionnaire items, and the ease of understanding and following completion instructions. All participants were able to successfully complete the questionnaire booklet. Minor rewording was made to some items to make them more appropriate for older adults.

5.2.4 Procedure

All participants were sent in the post a cover letter and information form explaining the nature of the study; a questionnaire booklet; and a freepost researcher addressed envelope so that participants could return at no financial cost to themselves the completed questionnaire booklet.

For those participants who indicated agreement to complete the follow-up component, participants were sent in the post one month later a cover letter and information form explaining the nature of the follow-up component; a copy of the Importance of Religious Ritual Scale; and a freepost researcher addressed envelope.

For both the questionnaire booklet and the follow-up component, if no response was received after three months, participants were sent the questionnaire booklet or follow-up component again.

5.3 Results

The following results section reports on the main areas of analysis that detail the preliminary psychometric properties for the newly developed instrument to measure religious ritual. This instrument is called the Importance of Religious Ritual Scale. Results are presented that detail the factor analysis of the scale, internal consistency reliability, construct validity, and test-retest reliability. The results section concludes with an exploratory analysis of differences in health, quality of life, life satisfaction, and religious variables between older adults who have experienced spousal bereavement and those who have not. However, first, a brief overview is provided on the scale's construction and scoring system.

5.3.1 Development of a Scale to Measure Religious Ritual: Importance versus Frequency

One of the first decisions that needed to be made was whether to measure importance or frequency of religious ritual. Importance of religious ritual in the life of an individual was selected over how often an individual engaged in religious ritual primarily because it was felt that whether an individual believed that ritual was important to them was more psychologically and emotionally significant than how often they behaviourally engaged in religious ritual. In addition, in the context of older adults who may not be able to engage in ritual as frequently due to age-related declines but for whom ritual still holds significance and meaning, importance of religious ritual was considered the more theoretically interesting and appropriate approach to exploring this construct. Indeed, it was felt that exploring the importance of religious ritual would allow for a deeper examination, compared with examining frequency.

5.3.2 Item Selection: Content Validity

The development of the Importance of Religious Ritual Scale was an iterative process involving a number of phases of development; numerous redrafts; and frequent discussions with Christian members and ministers, and psychology of religion academics. A concise overview is offered here.

The first phase of development involved item selection and was influenced by several different sources. For example, from the findings of Study 1 and specifically Study 2; in discussion with Church of England/Anglican, Orthodox, and Roman Catholic members and ministers; from attendance at Christian religious services; through consulting the opinions of psychology of religion academics; and from the theoretical literature on religious ritual and

practice. From these sources an overall 51-item master copy version of the Importance of Religious Ritual Scale was created (see Appendix X).

In contrast to many religious practice scales that have tended not to include items specifically addressing particular rituals, it was decided that the Importance of Religious Ritual Scale should attempt to measure as many of the widely endorsed Christian religious rituals as possible without being too esoteric or specialised. In addition, the scale would also measure theorised cognitive and emotional processes experienced during religious rituals.

Consideration was also given to selecting items that would be inclusive not just of Christians with a strong belief and practice but also of Christians with a moderate or weakly held belief but for whom certain rituals still held some significance or importance, and items that might hold the potential of generalising to other Christian groups or denominations around the world.

A secondary phase involved discussing and consulting again with Christian ministers and members about the most recent draft version of the scale and incorporating their comments into an updated version. During this phase the scale was reworded and reduced from 51 items down to 38 items (see Appendix Y). Items were removed based on some of the following criteria: items not being considered rituals; items being considered too specific to only one denomination; and item repetition. A more concise version of the scale was considered optimal because it would help factor analysis statistical procedures, and would be less demanding for older adult respondents.

In the final 38-item version, the first 25 items aimed to capture the widely endorsed Christian rituals that many Christians would be familiar with and that would hold some significance and meaning, with the remaining 13 items measuring the theorised cognitive and emotional processes experienced during religious rituals.

5.3.3 Response Format and Scoring

Each item took the form of a statement or proposition that participants indicated their level of agreement with. A five point Likert response format (i.e. 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree) was chosen for the scale as this format has been used successfully in other prominent psychology of religion scales (e.g. the Religious Orientation Scale, Allport & Ross, 1967) and is considered an optimal format in conventional scale construction (Mitchell & Jolley, 1996). Broadly speaking, a 3 to 4 point response format was considered slightly too limiting and would reduce variability in participant scores and

ability to detect individual differences, while a 6 to 7 point format was considered too long and demanding. An overall score is derived from summing individual scores on each item, with higher scores indicating greater importance of religious ritual in the life of the individual. In this preliminary version of the scale scores ranged from 38 (no importance of religious ritual) to 190 (high importance of religious ritual).

5.3.4 Principal Component Analysis

Principal component analysis (PCA) was carried out to explore the underlying factor structure of the 38-item version of the Importance of Religious Ritual Scale. PCA was carried out in accordance with the theoretical and practical guides to using factor analysis by Field (2005), Howitt and Cramer (2001), Brace, Kemp, and Snelgar (2006), and Pallant (2005).

Prior to analysis the data was inspected for suitability in factor analysis. The Kaiser-Meyer-Olkin statistic was 0.96, above the recommended criteria of 0.6, and the Bartlett's Test of Sphericity was statistically significant, thus providing support that the data had good factorability. The selection criteria for factors was the conventional method and that recommended by Field (2005; originally by Kaiser, 1960) whereby factors with eigenvalues of 1.0 or greater were retained for further investigation. Oblique rotation was selected and the method used was direct oblimin. Oblique rotation was selected because it was believed that if factors did exist within the religious ritual scale then these factors would likely be related, and thus correlate, with one another. Interestingly, Field (2005) suggests that oblique rotation be the preferred method of rotation in psychological research. According to Field (2005) orthogonal rotation, that assumes that underlying factors are unrelated, is unrealistic because psychological constructs are rarely entirely independent from other psychological constructs.

The first PCA identified five factors that accounted for 77% of the variance in religious ritual scores. Within this analysis, item 23 formed a factor of its own and items 37 and 38 also formed a separate factor, and these items failed to load highly on to any of the other factors. As factors formed by these items were difficult to interpret in the context of the other factors these three items were removed. A second PCA was then conducted on the remaining 35 items. The second PCA identified three factors that accounted for over 75% of the variance in religious ritual. The results of this second PCA can be seen in Table 14. The factor loading of 0.4 or greater was selected as the criteria for items making a significant contribution to a factor. As can be seen in Table 14 the majority of items loaded exclusively onto one factor. Sixteen items loaded onto factor one, nine items loaded onto factor two, and ten items loaded onto factor

three. Based on the common themes between items loading onto each factor, preliminary labels were created to summarise and describe each factor.

The label selected for factor one was "cognitive and emotional benefits of religious ritual". This factor represented predominantly the cognitive and emotional benefits derived from engaging in Christian religious rituals, and included the five primary Christian rituals of attending church, importance of religious ceremonies, prayer, reading scripture, and receiving Holy Communion/the Eucharist. Factor two was labelled "Catholic ritual" as it reflected how many of the rituals in this factor are associated with the Roman Catholic branch of Christianity. Factor three was labelled "aesthetics/appreciation of ritual" as many of the items focused on an appreciation for the components within Christian religious rituals. Finally, Table 15 shows that each of the factors correlated positively with one another and thus justifies the use of oblique rotation. Factor one and three had a stronger relationship with each other than factor two had with factors one and three. Following PCA the final 35-item version of the scale used a scoring range between 35 and 175. The mean score on the scale was 84.64 (SD = 35.81).

Table 14. Factor analysis of the Importance of Religious Ritual Scale

	I	II	III
Factor I: Cognitive/emotional benefits			
30. Through religious rituals I feel a greater sense of control over events in my life.	**0.98**	0.00	-0.05
29. Religious rituals strengthen or reaffirm my religious or spiritual beliefs.	**0.96**	-0.02	0.00
26. I feel able to communicate with God through religious rituals.	**0.95**	0.00	-0.03
31. Religious rituals help me to express my inner thoughts or feelings.	**0.94**	0.02	-0.02
28. Religious rituals give me personal strength during times of difficulty.	**0.94**	-0.01	0.01
27. Engaging in religious rituals calm any worrying thoughts I have.	**0.92**	-0.04	0.05
3. Prayer is an important part of my religious practice.	**0.91**	0.04	-0.00
35. I find religious rituals reassuring and comforting.	**0.88**	-0.03	0.09
33. I feel closer to others through religious rituals.	**0.76**	0.03	0.12
5. Reading religious scripture (e.g. the Bible) is an important part of my religious practice.	**0.76**	0.11	0.07
34. Through religious rituals I feel I can identify with or influence religious deities or God.	**0.74**	0.20	-0.07
1. Attendance at church is an important part of my religious practice.	**0.61**	0.01	0.31
25. The saying of grace before meals is important to me.	**0.60**	0.19	0.06
32. I feel closer to God during religious rituals.	**0.58**	0.06	0.33
2. Religious ceremonies are an important part of my religious practice.	**0.46**	0.18	0.34
4. Receiving Holy Communion (the Lord's Supper, the Eucharist) is important to me.	**0.45**	0.13	0.41
Factor II: Catholic ritual			
16. Venerating religious icons, crucifixes and relics of saints, is an important part of my religious practice.	-0.03	**0.92**	0.01
6. Using a prayer rope or set of beads (e.g. the rosary) is important to me.	0.03	**0.89**	-0.11
11. The use of incense in religious ceremonies is important to me.	0.07	**0.87**	-0.12
15. Venerating the 14 Stations of the Cross is important to me.	-0.04	**0.85**	0.12

	I	II	III
12. Fasting during religious festivals is an important part of my religious practice.	0.14	**0.74**	0.06
9. Making the sign of the cross is important to me.	0.05	**0.71**	0.18
10. Religious candle lighting is an important part of my religious practice.	0.18	**0.65**	0.06
21. Visiting or making pilgrimages to holy religious sites is important to me.	0.23	**0.55**	0.08
19. Confession is an important part of my religious practice.	0.25	**0.49**	0.14
Factor III: Aesthetic appreciation			
17. The use of music in religious ceremonies is important to me.	0.13	-0.16	**0.85**
20. The role of religious ministers in religious ceremonies is important to me.	0.05	0.03	**0.84**
13. Singing in church is an important part of my religious practice.	0.19	-0.12	**0.79**
24. The conduct of religious ministers during religious ceremonies is important to me.	0.12	-0.01	**0.76**
22. The order, precision, and standardisation of religious ceremonies are important to me.	-0.07	0.23	**0.74**
14. Worship on annual holy days (e.g. midnight mass for Christmas) is an important part of my religious practice.	0.19	0.09	**0.69**
7. Religious rites of passage (e.g. baptisms, confirmations, marriages, funerals) are important to me.	0.28	-0.01	**0.61**
18. Religious processions are important to me.	-0.20	0.42	**0.60**
8. Kneeling or bowing in church is important to me.	-0.05	0.40	**0.55**
36. I believe religious rituals are authorized by God.	0.23	0.20	**0.47**

Table 15.

Correlations between religious ritual factors

	Factor 1	Factor 2	Factor 3
Factor 1	-		
Factor 2	0.50	-	
Factor 3	0.66	0.52	-

5.3.5 Internal Consistency Reliability

Following the recommendation of Field (2005), internal consistency reliability using Cronbach's alpha was calculated for each individual factor and then overall for the entire scale. The alpha level for factor one was 0.98, for factor two was 0.94, and for factor three was 0.94. The overall scale had a Cronbach's alpha of 0.98. The internal consistency reliability scores for the Importance of Religious Ritual Scale are all high and suggest that items are measuring a similar construct. Moreover, this is perhaps what would be expected from a scale measuring a distinctive construct such as religious ritual.

5.3.6 Construct Validity

The process of validating the Importance of Religious Ritual Scale was based on the theoretical guides to validating newly developed questionnaires by Nunnally (1994) and Mitchell and Jolley (1996). According to Mitchell and Jolley (1996), a scale's construct validity can be supported by demonstrating convergent validity and discriminant validity. In the present study in order to establish convergent validity the Importance of Religious Ritual Scale was correlated with religious constructs thought to be similar or related to ritual. The constructs selected for convergent validity included Maranell's (1974) religious ritualism subscale, and Idler et al's. (2003) subscales of public religious practice and private religious practice. In addition, measures of frequency of service attendance and frequency of prayer were also used. Positive correlations between the Importance of Religious Ritual Scale and these measures of religious practice and ritual would provide some support that the Importance of Religious Ritual Scale is tapping into the construct of religious ritual a more specific form of religious practice.

In order to establish discriminant validity the Importance of Religious Ritual Scale was correlated with religious and secular variables thought to be dissimilar to religious ritual. The religious constructs selected were religious coping and religious forgiveness. The secular construct selected was social desirability bias and this was represented by two different dimensions: (i) self-deceptive enhancement (SDE), and (ii) impression management (IM). Low correlations between the Importance of Religious Ritual Scale with religious forgiveness and religious coping, and near zero correlations with SDE and IM would provide some support that the Importance of Religious Ritual Scale is measuring a separate dimension of religiosity and is unrelated to social desirability.

5.3.6.1 Convergent Validity

Table 16 shows the correlations for the Importance of Religious Ritual Scale (labelled "religious ritual") with each of the religious and social desirability variables. Spearman's rho correlations were used throughout as some of the variables were non-normally distributed.

Table 16 shows that the Importance of Religious Ritual Scale correlated positively with Maranell's (1974) ritualism domain (0.74), public practice (0.76), private practice (0.76), frequency of service attendance (0.78), and frequency of prayer (0.73). Taken together, these correlations lend support for the idea that the Importance of Religious Ritual Scale is measuring the religious rituals involved in public and private religious practice, and involved in church service ceremonies and prayer, which is what was expected. Interestingly, both public and private religious practice only correlated at approximately 0.4 with Maranell's (1974) ritualism domain, suggesting that these scales are not as highly related to ritual and more reflective of general practice.

5.3.6.2 Discriminant Validity

Table 16 shows that the Importance of Religious Ritual Scale correlated less highly with religious forgiveness (0.48) and had no correlation with SDE (-0.04) and IM (-0.01). These correlations lend support for the idea that the Importance of Religious Ritual Scale is not measuring to the same extent unrelated religious dimensions or social desirability.

Interestingly, there was a higher than expected correlation between the Importance of Religious Ritual Scale and religious coping (0.69), and this correlation does not entirely support discrimination from religious coping even though the items on each scale are very different. However, on reflection this is perhaps not totally surprising as some of the items on the

Importance of Religious Ritual Scale (particularly in factor one) do tap into the use of ritual in a coping context. Therefore, the higher than expected correlation between the Importance of Religious Ritual Scale and religious coping suggests that the ritual scale may be able to measure the use of ritual in religious coping as opposed to the use of religious belief in coping as measured by the religious coping scale. Therefore, and in summary, the Importance of Religious Ritual Scale can be thought of as measuring religious ritual per se (Maranell, 1974), but also aspects of public and private religious practice (Idler et al. 2003), and the use of ritual in religious coping (Idler et al. 2003). As such the Importance of Religious Ritual Scale may make an important contribution to understanding religious coping, specifically the use of religious ritual behaviour in coping.

Table 16.

Correlation matrix for religious ritual with religious and social desirability variables

	1	2	3	4	5	6	7	8	9	10
1. Religious ritual	-									
2. Maranell ritual	0.74**	-								
3. Public practice	0.76**	0.47**	-							
4. Private practice	0.76**	0.43**	0.81**	-						
5. Church attendance	0.78**	0.49**	0.86**	0.75**	-					
6. Prayer	0.73**	0.37**	0.69**	0.88**	0.70**	-				
7. Religious coping	0.69**	0.37**	0.68**	0.80**	0.63**	0.72**	-			
8. Religious forgiveness	0.48**	0.23**	0.50**	0.59**	0.45**	0.53**	0.65**	-		
9. SDE	-0.04	-0.03	-0.04	-0.03	-0.03	-0.03	-0.09	-0.00	-	
10.IM	-0.01	-0.00	-0.03	-0.01	-0.03	0.03	-0.00	0.04	0.42**	-

* $p < 0.05$; ** $p < 0.01$.

To investigate further the potential of the Importance of Religious Ritual Scale in measuring the use of ritual in religious coping, correlations were carried out comparing the relationship between religious ritual and religious coping with the SF-36 health dimensions, quality of life, and life satisfaction. Interestingly, the correlational analyses in Table 17 reveal that there is an inverse relationship between the Importance of Religious Ritual Scale and each of the SF-36 dimensions, quality of life, and life satisfaction. More specifically, the Importance of Religious Ritual Scale has a statistically significant inverse relationship with the following health and quality of life variables: General health perception (-0.14), physical functioning (-0.17), role limitations due to emotional problems (-0.23), social functioning (-0.17), bodily pain (-0.19), mental health (-0.19), energy and vitality (-0.15), and quality of life (-0.17). Importantly, this pattern of inverse correlations is very similar to the set of inverse correlations that religious coping has with the SF-36, quality of life, and life satisfaction. These results suggest that in this sample of older adults when health and quality of life scores were low reflecting poorer well-being, religious coping and religious ritual scores were high reflecting greater importance. These findings suggest that religious ritual may be used as a coping resource in British older adults.

Table 17.

Correlations for religious ritual and religious coping with SF-36 health dimensions, quality of life, and life satisfaction

	Religious Ritual	Religious Coping
General health perception	-0.14*	-0.19**
Physical functioning	-0.17**	-0.14*
Role limitation physical	-0.10	-0.20**
Role limitation emotion	-0.23**	-0.22**
Social functioning	-0.17**	-0.13*
Bodily pain	-0.19**	-0.24**
Mental health	-0.19**	-0.17**
Energy and vitality	-0.15*	-0.22**
Quality of life	-0.17**	-0.21**
Life satisfaction	-0.09	-0.11

* $p < 0.05$; ** $p < 0.01$.

5.3.6.3 Known-groups Discrimination

As a final method of establishing convergent and discriminant validity, the known-groups technique (Mitchell & Jolley, 1996) was employed. In the present study, this technique involved examining how well the Importance of Religious Ritual Scale discriminated between groups of participants expected to differ based on their self-report strength of religious/spiritual belief. Using the Royal Free Interview schedule, participants were categorised by strength of belief as follows: 1) no/low belief; 2) moderate belief; and 3) strong belief. It was predicted that those with a stronger religious/spiritual belief would score higher on the Importance of Religious Ritual Scale compared with those with a weaker strength of religious/spiritual belief.

Using Importance of Religious Ritual score as the dependent variable, and strength of belief as the independent variable, a one-way-ANOVA revealed that there was a significant difference in Importance of Religious Ritual scores between the three strength of belief groups (F=124.41, p<0.001). Follow-up analysis using three Bonferroni corrected independent t-tests revealed that those with a strong belief (N=42, M=121.63) had a significantly higher mean Importance of Religious Ritual score compared with those with a moderate belief (N=129,

M=94.13) (t=6.58, p<0.001), and compared with those with no/low belief (N=82, M=51.06) (t=18.03, p<0.001). Furthermore, those with a moderate belief had a significantly higher mean Importance of Religious Ritual score compared with those with no/low belief (t=12.58, p<0.001).

5.3.7 Test-Retest Reliability

To establish test-retest reliability, or temporal reliability, for the Importance of Religious Ritual Scale, 213 participants completed the scale again one month after originally completing it. The correlation between completing the Importance of Religious Ritual Scale at time one and completing the scale again one month later was 0.94. When this correlation is squared it becomes 0.88 (88%), indicating that only 12% of the variation in Importance of Religious Ritual scores is explained by random error over a one month period. A test-retest reliability coefficient of 0.70 or higher is considered good (Mitchell & Jolley, 1996). This finding indicates that the Importance of Religious Ritual Scale has good test-retest reliability, and further emphasises that the Importance of Religious Ritual Scale has satisfactory psychometric properties. In addition, a paired sample t-test also revealed that there was no significant difference in the mean Importance of Religious Ritual score at follow-up (M=84.86) compared with at time one (M=83.50, t=-1.57, p>0.05).

5.3.8 Exploratory Bereavement Analysis

The final part of this analysis involves a brief exploration of any potential differences in dimensions of health, quality of life, life satisfaction, and religiosity between bereaved and non-bereaved older adults. This analysis is included in an attempt to help guide future empirical bereavement research. Table 18 shows the results of a series of independent sample t-tests on the primary independent variables used in the present study. Of particular note is that bereaved older adults scored significantly lower on each of the eight health dimensions of the SF-36, on quality of life, and life satisfaction.

Table 18.

Comparisons between bereaved and non-bereaved older adults on dimensions of health, quality of life, life satisfaction, and religiosity

	Bereaved		Non-bereaved		
	M	SD	M	SD	*t*
General health perception	54.96	23.36	66.55	17.07	-3.82**
Physical functioning	56.68	28.06	76.39	22.26	-5.37**
Role limitation physical	39.86	44.16	67.09	39.36	-4.59**
Role limitation emotion	67.55	38.61	82.85	32.78	-2.98**
Social functioning	70.60	28.92	84.25	23.04	-3.60**
Bodily pain	64.36	25.21	73.01	23.16	-2.62**
Mental health	71.56	19.72	79.59	13.64	-3.19**
Energy and vitality	54.05	22.20	63.59	18.30	-3.26**
Quality of life	30.24	5.30	32.14	4.83	-2.73**
Life satisfaction	23.36	5.99	25.67	6.29	-2.64**
Religious belief	27.74	16.91	25.23	18.36	1.01
Religious ritual	92.62	33.73	81.28	36.30	2.30*
Ritual (Maranell)	19.36	12.15	15.20	11.91	2.49*
Religious coping	12.73	4.63	11.94	4.85	1.19
Religious forgiveness	8.02	2.99	7.35	2.94	1.64
Public practice	5.76	2.75	5.02	2.94	1.83
Private practice	15.31	8.27	13.03	8.11	2.00*
Frequency of service attendance	2.71	1.40	2.08	1.41	3.21**
Frequency of prayer	3.70	2.20	3.08	2.11	2.06*

* $p < 0.05$; ** $p < 0.01$.

Interestingly, however, bereaved older adults scored significantly higher on importance of religious ritual, Maranell's (1974) ritualism subscale, private religious practice, frequency of service attendance, and frequency of prayer.

5.4 Discussion

The aim of the present study was to develop, test, and provide preliminary psychometric properties (i.e. validity, reliability, factor structure) for one of the first scales within the psychology of religion and spirituality to be dedicated to measuring religious ritual. The name given to this instrument is the Importance of Religious Ritual Scale. This scale focuses on the importance of mainly Christian religious ritual in the life of an individual.

5.4.1 Validity

In the present study, it is proposed that the newly developed scale has good content validity as efforts were made to sample and select items based on the opinions and feedback of religious members and ministers, as well as being informed by the two qualitative studies with religious older adults reported earlier. In addition, the results of the present study offer support for the construct validity of the scale by demonstrating convergent and discriminant validity in accordance with the principles for establishing scale validity described by Mitchell and Jolley (1996) amongst others (e.g. Nunnally, 1994).

The scale showed good convergent validity by correlating positively and highly with a separate measure of religious ritual (i.e. Maranell's 1974 ritualism subsection) and with measures of religious practice that included public religious practice, private religious practice, frequency of church service attendance, and frequency of prayer. These relationships provided support that the Importance of Religious Ritual Scale was tapping into religious-practice based rituals, both public and private in nature. The Importance of Religious Ritual Scale also showed good discriminant validity by correlating to a lower extent with religious forgiveness in comparison with ritual and practice measures, and by having no correlation with social desirability (i.e. self-deceptive enhancement and impression management). In addition, the scale was able to discriminate between those likely to have a high, moderate, and low/no importance of religious ritual based on strength of religious/spiritual belief. Those with a stronger belief scored higher on importance of religious ritual compared with those weaker in strength of belief.

5.4.2 Reliability

The reliability of the Importance of Religious Ritual Scale was established using two separate criteria, internal consistency reliability and test-retest reliability. The results revealed that the scale had high internal consistency reliability not just at the level of the overall scale

but also within each factor. These findings provided support that items on the scale were measuring the same construct of importance of religious ritual. The results also showed that the scale had good test-retest reliability over a one month period and provided support for the scale's temporal reliability. Taken together these findings suggest that items on the scale produce stable and consistent scores.

5.4.3 Factor Structure

One particularly interesting set of findings came from the results on the underlying factor structure of the Importance of Religious Ritual Scale. Principal component analysis revealed that the scale had a three factor structure. These factors can be interpreted as representing different dimensional aspects of religious ritual within the scale.

The first factor, labelled "cognitive and emotional benefits of religious ritual", focused on how engagement in religious rituals can facilitate and foster thoughts or feelings that are experienced as beneficial or positive, such as a sense of control, reassurance, or closeness. As such, this factor captures some of the therapeutic properties, meaning, and purpose of religious ritual discussed in the theoretical literature. This factor also included items on the importance of major Christian rituals such as prayer, reading religious scripture, receiving Holy Communion/the Eucharist, and attending church and religious ceremonies, rituals familiar to most Christian denominations.

The second factor, labelled "Catholic ritual", focused on the importance of a group of rituals that are perhaps most often associated with Roman Catholicism or perhaps Eastern Orthodoxy. This factor included items on the importance of venerating religious icons, crucifixes, and relics of saints; and on the importance of fasting, using the rosary, making the sign of the cross, and confession.

Finally, the third factor, labelled "aesthetics/appreciation of religious ritual", focused on an appreciation of components within and related to religious rituals, for example on the role of religious ministers and the use of music and singing; on the standardisation and performance of ritual; as well as on the importance of rites of passage and worship on annual holy days. As such this factor captured an aspect of the form of religious ritual that is seldom discussed in the theoretical literature.

5.4.4 Religious Coping

One finding that did not entirely support discriminant validity was the relationship between the Importance of Religious Ritual Scale and religious coping which was higher than anticipated. However, this finding raised the possibility that religious ritual may also function as a method of religious coping. To investigate this idea further a series of correlations were carried out examining the relationship between religious ritual and religious coping with each of the SF-36 health dimensions, quality of life, and life satisfaction. Interestingly, both religious ritual and religious coping showed similar inverse relationships with each of the health and quality of life variables. These results suggested that as health, quality of life, and life satisfaction declined in this sample of older adults, religious ritual and religious coping became more important.

Additional support for the role of religious ritual in coping comes from the results of the exploratory bereavement analysis. These results showed that those older adults who had experienced spousal bereavement scored lower on each of the health, quality of life, and life satisfaction variables compared with older adults who had not experienced bereavement from a spouse. However, the bereaved group scored significantly higher on the ritual and practice dimensions of religiosity. These results suggested that for those older adults who had experienced spousal bereavement, religious ritual and practice were more important.

Although the role of religious ritual as a coping resource needs more conclusive support, these findings are indicative of religious ritual perhaps being used as a type of religious coping. Future research exploring the role of personal beliefs in coping with bereavement should consider carefully also including measures of religious ritual and practice to see whether these findings are replicated.

5.4.5 Future Research

In thinking about future research, it should be remembered that this is only a preliminary scale and as such requires much further testing and refinement. Future research could target a number of limitations with the existing scale. One area of refinement would be to reduce further the number of items on the scale. The present version of the scale has 35-items and some researchers may be put off from using such a long scale especially in survey research where there is a preference for shorter scales. Future research could develop a short-form version of the Importance of Religious Ritual Scale and compare findings with the existing version. The present results indicated that the internal consistency reliability value for

the scale was very high. It is perhaps worth noting that longer scales often have higher alpha values than shorter scales, and that alpha values greater than 0.9 are often an indicator of "item redundancy" on a scale (Field, 2005; Haywood, Garratt, & Fitzpatrick, 2005).

Item wording could also be refined further or modified to increase such things as generalizability. Examples of refining item wording could include replacing "church" with "place of worship", "venerating religious icons" with "venerating religious images", "kneeling or bowing" with "physical prostration", "use of a prayer rope or set of beads" with "use of aids to prayer", and "saying of grace before meals" with "prayers of thanksgiving before meals". These sorts of modifications would make the scale more inclusive of other religions or spiritual practices. Indeed, in future research it would be interesting to use the scale with different Christian denominations, other world religions, and younger age groups to examine any variations in scores.

5.4.6 Summary

In summary, the present study has developed and provided preliminary psychometric properties for a scale to measure religious ritual. The Importance of Religious Ritual Scale has attempted to be conscientious to ritual elements such as form, meaning, and purpose, as well as to elements tapping into psychological and emotional therapeutic properties. As an important dimension of religiosity, this scale of religious ritual can now be used in Study 4 (Chapter 6) alongside competing religious and secular variables in predicting grief, depression, and anxiety.

Chapter 6
Religious and Non-Religious Variables in Predicting Grief, Depression, and Anxiety in Recently Bereaved Older Adults

6.1 Introduction

The purpose of this fourth and final study was to use the newly developed scale of religious ritual in a study examining the influence of the major dimensions of religion on bereavement outcome in comparison with influential secular variables. This would be an exploratory study that would attempt to identify whether when hypothesised influential variables are considered in the same context, some variables establish themselves as more influential than others. Based on the religion and bereavement literature, seven religious variables and nine secular variables were identified as potentially influential and are briefly discussed below in more detail.

6.1.1 Religious Variables

In considering the religious variables to include in the present study, it can be discerned from recent reviews (e.g. Becker et al. 2007; Wortmann & Park, 2008, see section 2.5) that many studies have often used composite measures of religion that include items measuring multiple religious dimensions (e.g. belief, practice, importance of religion, religious coping). These composite measures make it difficult to identify exactly what dimensions of religion are having the most significant effect on bereavement outcome or are experienced as most useful or beneficial. In addition, other studies have often only included scales or single items measuring one or two dimensions (e.g. belief or practice), leaving the influence of other religious dimensions unexplored and unaccounted for. Few if any studies have compared the influence of multiple separate dimensions of religion on bereavement outcome in the same study. With these measurement issues in mind it was desirable in the present study to measure and thus represent religion along its primary experiential dimensions, those of cognition, behaviour, emotion, and social interaction, the dimensions most likely to be potentially influential.

Religion at the cognitive level refers to the content of beliefs and the strength with which beliefs are held, and along with frequency of church attendance has perhaps received the most research attention. Some research has already demonstrated that strength of belief is related to lower grief (Brown, Nesse, House, & Utz, 2004; Walsh, King, Jones, Tookman, & Blizard, 2002) and increased psychological well-being (Fry, 2001), although not all studies have found religious belief to have an influence on bereavement outcome (Stroebe & Stroebe,

1993). With regard to religious behaviour this has often been measured by attendance at religious services or importance of religious practice and has produced mixed findings. Some studies have found higher levels of church attendance or religious practice to be related to lower levels of depression (Bornstein, Clayton, Halikas, Maurice, & Robins, 1973; Higgins, 2002; Nolen-Hoeksema & Larson, 1999; Siegel & Kuykendall, 1990) and positively related to positive affect (McGloshen & O'Bryant, 1988), while other studies have found no association with bereavement outcome (Easterling, Gamino, Sewell, & Stirman, 2000; Fry, 2001; Stroebe & Stroebe, 1993). In the present study religious behaviour will be measured by the newly developed scale to measure importance of religious ritual (see Chapter 5). This scale is more specific than measures of general attendance or practice and taps into the religious rituals that circumscribe and guide religious practice. In their review of the religion and bereavement research, Koenig, McCullough, and Larson, (2001) suggested that religious ritual may be one particular aspect of religion that may facilitate the bereaved in grieving and adjusting to their loss (see also section 5.1.5 for a discussion of the therapeutic properties of religious ritual).

In addition, the present study will also include measures of frequency of church attendance and frequency of prayer. These frequency variables are included as these measures have been used more widely in the larger body of religion and health research that often uses cross-sectional designs. Although the majority of this research has demonstrated positive associations with health and well-being outcomes, no associations and negative associations have also been observed (Koenig, McCullough, & Larson, 2001). Interestingly, within the bereavement and religion research, prayer has received little attention in quantitative studies. One exception has been in recent research by Roff, Durkin, Sun, and Klemmack (2007) who found that prayer was used more frequently by bereaved older adults compared with married older adults, and that frequency of prayer was inversely related to well-being.

Religious emotion refers to the religious or spiritual feelings that can accompany religious/spiritual belief and practice and can be experienced as reassuring or comforting. Similar to the case for religious ritual, the influence of religious emotion has been under researched in religion and bereavement research and within the psychology of religion literature more generally. However, one study by Levy, Martinkowski, and Derby (1994) does provide some reason to believe that religious/spiritual emotions or feelings may be helpful in coping with bereavement. In their study of bereaved older adults, Levy et al. (1994) found that spiritual support, measured by items tapping into religious/spiritual emotion such as feeling a

close relationship with God and feeling God's love and care on a regular basis, was associated with lower levels of depression and fewer intrusive thoughts and feelings.

Religious social interactions refers to the interpersonal social experiences that people have within their religious social group, and is usually assessed in coping research by perceived accessibility to social support specifically from one's religious congregation, and experiences of conflicts or difficulties within one's religious group. In the context of bereavement very little research has examined the influence of religious social support, however what studies there are offer mixed findings. One study by Fry (2001) did find that accessibility to religious social support was related to increased psychological well-being in recently bereaved older adults. However, a study by Richardson and Balaswamy (2001) of elderly widows found that attendance at church social events was associated with increased negative affect for those early in their bereavement (widowed less than 500 days) and less positive affect for those later in their bereavement (widowed more than 500 days).

Finally, spiritual capital will also be measured in the present study. Spiritual capital is a relatively new concept in religion and bereavement research and refers to the level of engagement in roles or tasks on behalf of one's church, in addition to or separate from attending religious services. This variable is included as Study 2 (see section 4.3.6) suggested that this activity was important in coping with bereavement by providing or preserving meaning and purpose in one's life.

6.1.2 Secular Variables

With regard to the secular variables included in the present study, these are organised into three broad groups. First are socio-demographic variables; second are known influential variables; and third are hypothesised influential but not empirically tested variables. These three groups and the individual variables that make up these groups are briefly discussed below.

It can be discerned from the religion and bereavement literature that the socio-demographic variables that have most often been included in research and statistically controlled for are age, gender, and socioeconomic status. Furthermore, reviews of the bereavement research using these socio-demographic variables have generally concluded that bereavement outcome is worse for males, adults younger in age, and those lower in socio-economic status (Hansson & Stroebe, 2007; Stroebe & Schut, 2001).

Amongst the known variables that have been considered influential on bereavement outcome, two that are particularly notable, and are separate in nature from socio-demographic

variables, are social support and physical heath status. These variables have been frequently included in studies and have been widely discussed in the bereavement literature. Reviews of the literature have generally concluded that social support can be beneficial to the bereaved by providing instrumental support with restoration-oriented stressors, companionship to alleviate social loneliness, and may increase psychological well-being (Hansson & Stroebe, 2007; Stroebe & Schut, 2001). As for health status, conclusions suggest that poorer health or disability may exacerbate the stress of bereavement or impair one's ability to cope. This situation may be especially the case in later life, a period associated with a decline in health (Hansson & Stroebe, 2007).

Within the present study, perhaps more important than socio-demographic variables and known influential variables, whose influences have already been documented, are a number of other variables that have been hypothesised as potentially influential but have received little if any empirical attention. Three such variables are attachment style, grief rituals, and the helpfulness of the funeral service.

Of these three variables, attachment style has received the most theoretical attention. Indeed, attachment theory makes several predictions about how different attachment styles may influence bereavement outcome. For example, that those with an insecure anxious attachment style may be more likely to show a preoccupation with the loss and experience prolonged and intense grief; that those with an insecure avoidant attachment style may inhibit or distract themselves from their grief and show few signs of distress or grieving; and finally that those with a secure attachment style will sit somewhere in between the other two styles and show normal upset and sadness at the bereavement but show a gradual decline in grief as they come to terms with their loss (Hansson & Stroebe, 2007). The present study will investigate whether differences in attachment style are associated with differences in bereavement outcome.

Within the bereavement literature there has been surprisingly little research or theorising about grief rituals, even though these activities may be frequently used both publicly and privately (Castle & Phillips, 2003). Grief rituals have been described as post-funeral activities performed in relation to a deceased loved one that symbolically express grief-related thoughts and feelings (Castle & Phillips, 2003; Rando, 1985). As an aside, grief rituals share many of the same structural and functional properties as normal rituals (see section 5.1.1 for an in-depth discussion of ritual). Grief rituals are theorised as being beneficial during the grief process because amongst their hypothesised therapeutic properties they can help the bereaved approach the reality of the death; can act as vehicles for the expression of emotion; can help the

bereaved transform their ongoing relationship with the deceased; and can help the bereaved in the transition of their psychosocial identity (Castle & Phillips, 2003; Kobler, Limbo, & Kavanaugh, 2007; Romanoff & Terenzio, 1998). However, if grief rituals are not considered subjectively meaningful or relevant to one's bereavement or grief, they may be experienced as ineffective or unhelpful.

Perhaps one of the least theoretically discussed and empirically examined variables in the bereavement literature has been related to the perceived helpfulness of the funeral service in coping. This fact is surprising as the funeral service itself is considered to share many of the same therapeutic properties as grief rituals and are conducted in part to help the bereaved in coping (Irion, 1990-91; Romanoff & Terenzio, 1998). In addition, the majority of funerals are conducted within a religious tradition that often provide messages of hope or comfort, and have been hypothesised as a component related to religion that can help the bereaved cope with their grief (Koenig, McCullough, & Larson, 2001).

Finally, with regard to the measures of bereavement outcome in the present study, in line with recommendations in the bereavement literature, a broad approach will be taken (Hansson & Stroebe, 2007). The present study will have three separate dependent variables, grief, depression, and anxiety. Thus, unlike many other bereavement studies, this approach will ensure that a bereavement-specific measure is assessed as well as two related mental health variables.

6.1.3 The Present Study

The objective of the present study will be to control for the influence of socio-demographic variables and known influential variables, and investigate the influence of the hypothesised influential secular variables (i.e. attachment style, grief rituals, helpfulness of the funeral service), and religious variables (i.e. religious/spiritual belief, religious ritual, religious emotion, religious social support, church attendance, prayer, spiritual capital) on grief, depression, and anxiety in older adults who have recently lost a spouse. The aim will be to identify whether when secular variables are controlled do religious variables emerge as predictors of grief, depression, and anxiety, and if so which variables appear the strongest predictors. In addition, the study will also be able to identify whether when socio-demographic and known influential secular variables are controlled, do the hypothesised influential secular variables emerge as predictors of grief, depression, and anxiety, and if so which of these variables appear the strongest predictors of the dependent variables.

6.2 Method

6.2.1 Participants

The study used a self-selective, opportunity sample of 105 older adults who had all experienced bereavement from a spouse. The mean age of participants was 68.95 years, (SD) = 7.83 years, with an age range of 55 to 85 years. There were 82 (78.1%) females and 23 (21.9%) males. Participants were recruited through adverts placed in the local press, through posters placed in local community centres, libraries, and churches, and through a funeral director who had been involved in previous bereavement and personal beliefs research (see Coleman et al. 2002, 2007). The eligibility criteria for the study included being over the age of 55 years and having experienced bereavement from a spouse in the previous 48 months. A sample size estimation was made based on guides to using multiple regression analysis by Field (2005) and Pallant (2005). Although the present sample was slightly smaller than would be optimal it was considered acceptable as this was an exploratory study and was a difficult, esoteric, and somewhat specific population to recruit.

6.2.1.1 Sample Bereavement Characteristics

Table 19 shows that the mean time since bereavement from spouse was 1.64 years (1 year and 8 months) with a range of 2 months to 4 years. The mean length of time married was 41.12 years, with the mean age of experiencing spousal bereavement being 67.21 years.

Table 19.

Means, standard deviations, and age ranges for time since bereavement, number of years married, and participant age at time of bereavement.

	M	SD	Range
Time since bereavement	1.64 years	1.14 years	2 months – 4 years
Length of time married	41.12 years	10.92 years	9.75 - 64 years
Age at time of bereavement	67.21 years	7.99 years	51.09 – 84.84 years

Table 20 shows that approximately half of the sample had experienced an anticipated bereavement (51%) and half had experienced a sudden or unexpected bereavement (49%). The sample varied in the causes of death of participants' spouses. The most frequent cause of death was as a result of a specific type of cancer (38%), which was followed by deaths caused by

heart or lung conditions (29%). The next most frequent cause of death was specific or multiple organ failure (11%) which was closely followed by deaths as a result of a degenerative neurological disease (10%), and from a cerebral tumour or disease (7%). Other causes of death included nervous system disease, accidents, suicide, and alcoholism. The majority of participants had played some role in caring for their spouse prior to death (80%), and most of the sample reported having a cremation based funeral service for their spouse (88.5%).

Table 20.

Number of participants and percentage of sample for level of bereavement forewarning, causes of bereavement, carer for spouse prior to death, and type of funeral service held for spouse

	N	%
FOREWARNING		
Expected (chronic illness, months/years)	54	51%
Sudden (no forewarning or hours/days)	51	49%
CAUSES		
A form of cancer	40	38%
Heart or lung conditions (e.g. pneumonia, heart attack)	30	29%
Specific organ or multiple organ failure	12	11%
Degenerative neurological disease (e.g. dementia, Alzheimer's)	11	10%
Cerebral tumour or disease (e.g. stroke, brain tumour)	7	7%
Accident	2	2%
Nervous system disease	1	1%
Suicide	1	1%
Alcoholism	1	1%
CARER FOR SPOUSE		
Yes	84	80%
No	21	20%
TYPE OF FUNERAL SERVICE		
Burial	12	11.5%
Cremation	92	88.5%

6.2.1.2 Sample Religious Characteristics

Table 21 shows that 76% of participants indicated having a religious or spiritual understanding of their life, with the majority (41.3%) considering this understanding as being both religious and spiritual. Approximately 42.3% of participants indicated attending religious services up to once a month, with over two thirds of the sample (69.2%) indicating having some experience of attending religious services with some degree of regularity. Of those participants who did endorse attending religious services frequently, the majority indicated attending on a weekly basis (26%). Up to 72.1% of participants indicated some experience of engaging in prayer, with 39.4% of participants reporting that they prayed on a daily basis.

Table 21.

Number of participants, percentage and cumulative percentage of sample for religious/spiritual understanding of life, frequency of attendance at religious services, and frequency of prayer

	N	%	Cumulative %
Religious	24	23.1%	23.1%
Spiritual	12	11.5%	34.6%
Religious and Spiritual	43	41.3%	76%
Neither Religious nor spiritual	25	24%	100%
FREQUENCY OF ATTENDANCE AT RELIGIOUS SERVICES			
More than once a week	2	1.9%	1.9%
At least weekly	27	26%	27.9%
At least monthly	15	14.4%	42.3%
Less often	28	26.9%	69.2%
Rarely or never	32	30.8%	100%
FREQUENCY OF PRAYER			
Daily	41	39.4%	39.4%
More than once a week	13	12.5%	51.9%
At least weekly	7	6.7%	58.6%
At least monthly	5	4.8%	63.4%
Less often	9	8.7%	72.1%
Rarely or never	29	27.9%	100%

Table 22 refers to a new variable of interest referred to as spiritual capital. Table 22 shows that almost half of the sample (49.1%) had some regular experience of engaging in activities on behalf of the church in addition to attending religious services. Approximately 29.9% of the sample engaged in spiritual capital up to once a month.

Table 22.

Number of participants, percentages and cumulative percentages for engagement in spiritual capital

	N	%	Cumulative %
Daily	1	1.0%	1.0%
Every week or more often	8	7.7%	8.7%
Once or twice a month	11	10.6%	19.3%
Every month or so	11	10.6%	29.9%
Once or twice a year	20	19.2%	49.1%
Rarely or never	53	51.0%	100%

Table 23 shows that approximately 86.5% of participants indicated belonging to or identifying with some kind of religious or spiritual denomination, with approximately 85.6% indicating membership specifically to a Christian denomination. Up to 64.4% of participants indicated their denomination as being Church of England, 11.5% indicated Roman Catholic, and a further 9% were spread across other Christian denominations. Approximately 13.5% of participants indicated that they did not observe a religion.

Table 23.

Number of participants, percentages, and cumulative percentages for religious/spiritual denominational characteristics of the sample

	N	%	Cumulative %
Church of England/Anglican	67	64.4%	64.4%
Roman Catholic	12	11.5%	76%
Baptist	3	2.9%	78.8%
Methodist	5	4.8%	83.6%
Quaker	1	1.0%	84.6%
Church of Scotland	1	1.0%	85.6%
Spiritualist	1	1.0%	86.5%
I do not observe a religion	14	13.5%	100%

6.2.1.3 Sample Socio-demographic Characteristics

Table 24 shows that none of the participants had remarried following bereavement from their spouse, and that all participants were of Caucasian ethnicity. The sample contained a range of educational attainments, with the majority of participants indicating school or college as their highest level of education. The majority of participants reported that they were retired (76.2%), with most of the sample reporting their perception of their financial situation as good (45.7%).

Table 24.

Number of participants and percentages for socio-demographic details of the sample

	N	%
REMARRIED		
Yes	0	0%
No	104	99%
Missing	1	1.0%
ETHNICITY		
White	105	100%
Other	0	0%
EDUCATION		
School	57	54.3%
College	36	34.3%
University	9	8.6%
Postgraduate	3	2.9%
EMPLOYMENT STATUS		
Employed full time	7	6.7%
Employed part time	17	16.2%
Unemployed	1	1.0%
Retired	80	76.2%
PERCEPTION OF FINANCIAL SITUATION		
Excellent	5	4.8%
Very good	13	12.4%
Good	48	45.7%
Fair	31	29.5%
Poor	8	7.6%

6.2.2 Design

A cross-sectional survey design was used to examine the unique contribution of religious variables in comparison with a range of influential secular variables on grief,

depression, and anxiety in a sample of older adults who had experienced spousal bereavement in the previous 48 months.

6.2.3 Materials and Apparatus

An information/consent form (see Appendix Z) and debriefing form (see Appendix AA) were provided to all participants. The debriefing form contained the additional information of the contact details for "Cruse" a national bereavement organisation. This information was included in case any participants wanted to discuss or seek out further information related to their bereavement experience.

All questionnaire instruments used in the study were selected based on their established validity and reliability, and where possible for their use in previous research with older adults.

6.2.3.1 Socio-Demographic Information and Bereavement Characteristics

A socio-demographic questionnaire (see Appendix AB) was created to measure a number of socio-demographic variables and bereavement characteristics that would help to contextualise findings and were considered important in bereavement, religion, and ageing research. The socio-demographic variables included: age, gender, ethnicity, level of education, employment status, and perception of one's financial situation. The bereavement characteristics included: how long ago the spouse passed away, length of marriage to the deceased spouse, level of bereavement forewarning, cause of death of the spouse, whether the participant acted as the carer for the deceased spouse, and whether the participant had remarried following bereavement. The response format for the above items ranged from dichotomous responses (e.g. male/female, yes/no); multi-item responses (e.g. from excellent to poor); and free/open responses (e.g. age, cause of death).

6.2.3.2 Religious and Spiritual Belief

The Beliefs and Values Scale by King et al. (2006; see Appendix L) was used to measure strength of spiritual and religious belief (see section 4.2.3.2 for a description of the scale and for details of the scale's psychometric properties). In the present sample the Cronbach's alpha for the scale was 0.95. In addition, items from the Royal Free Interview for Spiritual and Religious Beliefs by King, Speck, and Thomas (2001; see Appendix F) were used to measure religious/spiritual understanding of one's life, frequency of attendance at religious services, and frequency of prayer.

6.2.3.3 Spiritual Capital

As there is no existing psychosocial scale to measure spiritual capital, one item was created to measure this construct. The item read as follows: "Besides your own religious activities, how often do you perform tasks on behalf of the church?" This item was measured along a six point response format ranging from: 6=daily, 5=every week or more often, 4=once or twice a month, 3=every month or so, 2=once or twice a year, 1=rarely or never. This item and the response format used was developed from item two of the public religious practice subsection of the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Fetzer/NIA, 1999; see Appendix S).

6.2.3.4 Importance of Religious Ritual

The newly developed 35-item scale of religious ritual was used to measure importance of religious ritual (see Appendix Y). See section 5.3 for a description of the scale and a review of the scale's psychometric properties. In the present sample Cronbach's alpha for the scale was 0.98.

6.2.3.5 Brief Multidimensional Measure of Religiousness/Spirituality

Religious/spiritual emotional experience and religious social support were measured using the Daily Spiritual Experience and Religious Social Support subsections of the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Fetzer/NIA, 1999; see section 5.2.3.5 for details about the psychometric properties of this questionnaire).

The *Daily Spiritual Experience* subsection (see Appendix S) was used to measure the emotional component of an individual's religious or spiritual belief. More specifically, the subscale was used to measure an individual's emotional experience and perception of their belief on a daily basis, as opposed to their cognitive understanding of their belief (Idler et al. 2003). The subscale features 6 items that refer to feelings elicited by, or of immersion within, one's religious or spiritual belief. Items are measured on a six point response format ranging from 1 (many times a day) to 6 (never or almost never). Scores were reversed and summed. Higher scores indicated greater daily experience of religious or spiritual feelings. In the present sample Cronbach's alpha was 0.90.

The *Religious Social Support* subsection (see Appendix S) was used to measure the help, support, and comfort provided specifically by one's religious group or congregation. The

subsection consists of 4 items, 2 items measuring anticipated support (e.g. If you were ill, how much would the people in your congregation help you out?) and 2 items measuring negative interaction (e.g. How often do the people in your congregation make too many demands on you?) Items were measured on a four point response format ranging from 1 (a great deal or very often) to 4 (none or never). Items measuring anticipated support were reversed and all four items were summed. Higher scores indicated greater perceived religious or spiritual based social support. In the present sample Cronbach's alpha was 0.94 for anticipated support and 0.83 for negative interactions.

6.2.3.6 Grief

The Inventory of Complicated Grief (ICG; Prigerson et al. 1995; see Appendix AC) was used to measure level of grief. The ICG is a measure of grief symptoms that unlike many other grief instruments is designed to measure the cognitive, emotional, and behavioural characteristics of grief that are distinguishable from symptoms of other emotional disorders such as depression and anxiety. In addition, the ICG has the unique ability of being able to distinguish between normal grief reactions and grief that may be associated with longer term quality of life impairments (referred to as complicated grief).

The ICG contains 19 items and uses a five point response format to measure the frequency with which each item is being experienced at the present time and ranges from 0 (never) to 4 (always). Overall summed scores can range between 0 and 76, with higher scores indicating increased severity of grief symptoms. Prigerson et al. (1995) have proposed that a score greater than 25 be considered a preliminary cut-off for potentially more problematic grief.

The ICG was uniquely developed and designed with non-traumatically conjugally bereaved older adults and has a good underlying factor structure, concurrent validity of 0.87 with the Texas Revised Inventory of Grief (Faschingbauer, Zisook, & DeVaul, 1987) and 0.70 with the Grief Measurement Scale (Jacobs et al. 1987), test-retest reliability of 0.80 over a 6 month interval, and internal consistency reliability of 0.94. In a review of widely employed grief measures by Neimeyer and Hogan (2001), the ICG was considered a promising if underused measure of grief and perhaps the strongest measure of grief with regard to support for its psychometric properties. In the present sample Cronbach's alpha was 0.93.

6.2.3.7 Non-Religious Grief Ritual

The ritual activities subsection of the Bereavement Activities Questionnaire (BAQ; Castle & Philips, 2003; see Appendix AD) was used to measure engagement in and usefulness of non-religious (secular) grief ritual. The scale consists of 25 post-funeral, non-religious, ritualistic grief activities that people often engage in when coping with bereavement (e.g. visiting a place that was special to the deceased; or writing a letter or poem to the deceased). The subsection asks participants to tick the ritual activities that they have engaged in to help them cope with their bereavement and then to rate the ritual activity for how helpful they found it to be. Each ritual activity item is measured along a five point response format ranging from 1 (very unhelpful) to 5 (extremely helpful). A final item on the scale is labelled "other activity" and allows participants to add any ritual activities they have engaged in and found useful that are not already included on the original subscale. Scoring involves responses being summed and an average being calculated ranging between 1 (very unhelpful) and 5 (extremely helpful). Thus, higher scores reflect the increased helpfulness of performing non-religious grief-related ritual activities during coping.

Although the psychometric properties for the scale have yet to be fully examined, Castle and Philips (2003) do provide some preliminary support that the scale has good content validity in research with recently bereaved adults and older adults. In the present sample Cronbach's alpha was 0.91.

6.2.3.8 Physical Health

The physical functioning subscale of the Short-Form 36-item (SF-36) Health Survey (Ware & Sherbourne, 1992; see Appendix T) was used to measure general physical health (see section 5.2.3.6 for a detailed description of the SF-36). The subsection contains 10 items that focus on level of physical functioning ability and is measured using a three point response format ranging from 1 (yes, limited a lot) to 3 (no, not limited at all). Scores for each item are summed and transformed to give an overall score ranging between 0 and 100, with higher scores indicating better physical health. In the present sample Cronbach's alpha was 0.90.

6.2.3.9 Depression

The Geriatric Depression Scale (GDS; Sheikh & Yesavage, 1986; see Appendix C) was used to measure depression (see section 3.2.3.1 for a description of the scale and for details about the scale's psychometric properties). In the present sample Cronbach's alpha was 0.88.

6.2.3.10 Anxiety

The anxiety subsection of the Hospital Anxiety and Depression scale (HAD-A; Zigmond & Snaith, 1983; see Appendix AE) was used to measure anxiety. The subsection focuses on the cognitive and emotional aspects of anxiety such as feelings of fear and panic, worrying thoughts, and feelings of uneasiness and restlessness and measures the severity with which these anxiety characteristics have been experienced in the previous week. The subscale contains seven items measured along a four point response format ranging, for example, from 0 (not at all) to 4 (definitely). Scores for each item are summed to give an overall score ranging between 0 and 21, with higher scores indicating increased severity of anxiety symptoms. In addition, Zigmond and Snaith (1983) have suggested that the HAD-A is a potential screening tool for anxiety disorders and have suggested some useful cut-offs. For example, a score between 0 and 7 is considered within the normal range, a score between 8 and 10 is considered an indicator of the possible presence of an anxiety mood disorder, and a score of 11 or above is considered an indicator of the probable presence of an anxiety mood disorder (Snaith 2003).

More recently, a review of the scale by Bjelland, Dahl, Haug, and Neckelmann (2002) and an empirical study by Flint and Rifat (2002) using older adults have both confirmed the psychometric properties of the HAD-A including a satisfactory underlying factor structure, good concurrent validity, and internal consistency reliabilities ranging between 0.68 and 0.93. Furthermore, despite the title, Snaith (2003) suggests the scale is suitable for use with community dwelling samples. In the present sample Cronbach's alpha was 0.91.

6.2.3.11 Adult Attachment

The Experiences in Close Relationship scale short-form (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007; see Appendix AF) was used to measure adult attachment. The 12-item ECR-S is derived from the longer 36-item Experiences in Close Relationship scale (ECR) by Brennan, Clark, and Shaver (1998) which is widely considered a seminal measure of adult attachment. Based on the underlying theory of the ECR, the ECR-S conceptualises adult attachment as consisting of two dimensions, namely: attachment anxiety and attachment avoidance. According to Wei et al. (2007) attachment anxiety is proposed to involve "a fear of interpersonal rejection or abandonment, an excessive need for approval from others, and distress when one's partner is unavailable or unresponsive" (p.188), while attachment avoidance is proposed to involve a "fear of dependence and interpersonal intimacy, an

excessive need for self-reliance, and reluctance to self-disclose" (p.188). Thus, the ECR-S is made up of two subsections with 6 items representing attachment anxiety and 6 items representing attachment avoidance. Each item is measured along a five point Likert response format ranging from 1 (strongly disagree) to 5 (strongly agree). Once negatively worded items have been reversed, item scores are summed for each subsection to give two separate scores, one score for attachment anxiety and one score for attachment avoidance. Higher scores indicate higher levels of insecure adult attachment (attachment anxiety and attachment avoidance) while lower scores indicate lower levels of insecure adult attachment or secure attachment.

Wei et al. (2007) have demonstrated that the ECR-S has good psychometric properties including underlying factor structure, construct validity, test-retest reliabilities greater than 0.80 over approximately a one month interval, and internal consistency reliabilities ranging from 0.78 to 0.86 for the anxiety subsection and 0.84 to 0.88 for the avoidance subsection. In the present sample Cronbach's alpha for the attachment anxiety subsection was 0.73, and for the avoidance subsection was 0.74.

6.2.3.12 Social Support

The MOS Social Support scale (Sherbourne & Stewart, 1991; see Appendix AG) was used to measure social support. The scale conceptualises social support as consisting of two primary factors, functional support which refers to the functions and purposes of interpersonal relationships, and structural support which refers to the existence and number of interpersonal relationships (Sherbourne & Stewart, 1991). The scale consists of 20 items designed to measure perceived availability of social support if needed. The first item measures structural support with regard to the number of close friends or relatives available to the individual, while the remaining 19 items measure functional social support within four different dimensions. These dimensional subsections are: emotional/informational support (8 items) which refers to the availability of others to provide emotional understanding, advice, and information; tangible support (4 items) which refers to the availability of others to provide physical help or assistance; positive social interaction (4 items) which refers to the availability of others to engage in enjoyable activities with; and affectionate support (3 items) which refers to the availability of others to provide love and affection (Sherbourne & Stewart, 1991).

The scale uses a five point response format ranging from 1 (none of the time) to 5 (all of the time). Items are summed and transformed to produce an individual social support score for

each subscale and an overall social support score across subscales. Scores range from 0 (no perceived availability of social support) to 100 (perceived social support available all the time). The scale is a widely used measure of social support that has good construct validity, test-retest reliabilities of between 0.72 and 0.78 over a one year interval, and internal consistency reliabilities ranging between 0.91 and 0.96 for the functional subscales, and 0.97 for the overall scale (Sherbourne & Stewart, 1991). In the present sample Cronbach's alpha for the overall scale was 0.96.

6.2.3.13 Perceived Helpfulness of Funeral Service

Two items were added to the end of the questionnaire on the insistence of our funeral director. The two items aimed to examine the type of funeral service the participant had for their spouse and how useful they found the service to be. Item one asked "What type of funeral service did you have for your spouse?" This item was followed by the responses "Burial", "Cremation", or "Other, please state". Item two asked "How helpful did you find the funeral service for your spouse? This item was followed by a five point response format ranging from: 1=very unhelpful, 2=unhelpful, 3=neither unhelpful nor helpful, 4=helpful, 5=very helpful.

6.2.3.14 Mood Repair Component

A mood repair component was created especially for the study with the purpose of concluding the questionnaire booklet on a positive note (see Appendix AH). The mood repair component was developed based on the Pleasant Events Schedule by MacPhillamy and Lewinsohn (1982), a 320 item inventory of enjoyable activities that has been used in clinical research on mood disorders. The mood repair component involved presenting participants with a list of 25 pleasant events appropriate to older adults and asking participants to tick all the events that they had engaged in during the previous four weeks and found enjoyable.

6.2.3.15 Overall Questionnaire Booklet

The individual questionnaire instruments were organised into an 18 page booklet that could be easily posted or administered to participants. On the front page of the booklet were brief instructions for completing the booklet, with the information/consent form appearing on the first inside page. The completion order was standardised for all participants and grouped into relevant blocks, for example with religious/spiritual scales appearing early in the booklet, followed by grief and mental health scales in the middle, and attachment and social support

scales toward the end. This strategy was used in order to facilitate ease of completion and to counter against any fatigue or boredom effects preventing participants from completing items on the key independent variables (religiosity measures) and dependent variables (grief/mental health).

The booklet had 14 sections with each section presenting a new questionnaire instrument. The questionnaire order of appearance in the booklet was as follows: 1) Socio-demographic information/bereavement characteristics; 2) The adapted Royal Free Interview for Spiritual and Religious Beliefs, spiritual capital, and Beliefs and Values scale; 3) The Importance of Religious Ritual Scale; 4) Daily Spiritual Experience; 5) Religious Support; 6) Inventory of Complicated Grief; 7) Bereavement Activities Questionnaire; 8) Physical Health; 9) Geriatric Depression Scale; 10) the HAD-A anxiety scale; 11) the ECR-S attachment scale; 12) the MOS Social Support scale; 13) Perceived helpfulness of the funeral service; and 14) the Pleasant Activities and Events Scale. The debriefing statement and a thank you appeared on the final page of the booklet.

Unique instructions for completing each questionnaire instrument appeared at the start of each new section. In developing the questionnaire booklet, every attempt was made to keep the booklet sections as logical as possible with regard to grouping similar themed scales together, as concise as possible by using short form measures where available, and in preventing against scale contamination effects. With regard to this latter point, after much reordering of scales, the ICG finally appeared before the GDS and HAD-A. This order was selected to prevent depression items inflating ICG scores. The physical health scale was placed between the ICG and GDS in an attempt to prevent ICG scores directly inflating GDS scores. Although not a perfect solution it was felt optimal for a booklet measuring both grief and depression.

6.2.3.16 Pilot Study

Five older adults who had experienced spousal bereavement were used in a pilot study to test the suitability of the questionnaire booklet for use with recently bereaved older adults. The pilot study would contribute toward ensuring that the questionnaire booklet was sensitive to the circumstances of the recently bereaved and would not unintentionally offend or upset potential participants. There were 4 females and 1 male in the pilot study, with a mean age of 76.80 years (SD=6.14 years), with an age range of 68 to 83 years, and time since bereavement was 3.30 years. These participants were asked to carefully read through the questionnaire

booklet and provide feedback about the suitability and sensitivity of the questionnaire instruments and item wording. In addition, two funeral directors were also consulted about the suitability of the questionnaire instruments and item wording. An academic with experience in bereavement research also provided comments on the proposed questionnaire instruments.

Based on feedback, minor item rewording was made to the socio-demographic questionnaire, and adult attachment scale, and rewording of the introduction to the inventory of complicated grief. A questionnaire to measure social desirability bias was removed from the final questionnaire booklet as it was considered inappropriate.

6.2.4 Procedure

Participants expressed their interest in participating in the study by contacting the researcher by telephone or email. Participants were then sent in the post a cover letter and information form explaining the nature of the study; a questionnaire booklet; and a freepost researcher addressed envelope so that participants could return at no financial cost to themselves the completed questionnaire booklet.

6.3 Results

The following data analysis is composed of three main parts. The first part will discuss the descriptive statistics for each of the main predictor and outcome variables. The second part will detail the bivariate correlations between the main predictor and outcome variables. Finally, the third part will present the hierarchical multiple regression analyses for each of the three outcome variables (i.e. grief, depression, anxiety).

6.3.1 Descriptive Statistics for Main Predictor and Outcome Variables

The means and standard deviations for the main predictor and outcome variables are presented in Table 25. The mean grief score for the sample was 28.81 which is higher than in previously reported studies of American older adults (e.g. Prigerson et al. 1995) but is perhaps unsurprising in a sample that is recently bereaved. Interestingly, 55 participants (52.3% of the sample) scored over 25 on the ICG, the proposed cut-off for probable complicated grief originally proposed by Prigerson et al. (1995). The mean score for anxiety was within the normal range while the mean score for depression was just within the range indicating the presence of possible depression. With regard to cut-offs, 49 participants (46.6% of the sample) scored 5 or higher on the GDS, the cut-off for possible depression, while 27 participants (25.7% of the sample) scored 11 or higher on the HAD-A, the cut-off for a probable anxiety disorder.

The mean scores on social support and physical health were both quite high reflecting a sample with adequate perceived access to social support and good physical health. The mean scores for attachment avoidance and attachment anxiety were both moderate with attachment anxiety slightly higher than avoidance. The mean score for perceived helpfulness of the funeral service was higher than expected and reflected that the sample considered the funeral service as being "helpful" to coping, while the mean score for engagement in secular bereavement activities/rituals suggested that these grief rituals were considered as "moderately helpful" by the sample.

With regard to the religious variables, on average the sample attended religious services between "at least monthly" and "less often", that on average they prayed between "at least weekly" and "monthly", and that they engaged in spiritual capital between "every month" and "once or twice a year". The mean score for religious/spiritual belief was quite high and comparable with studies of non-older adults (see King et al. 2006). Similarly, the mean score for importance of religious ritual was also quite high and slightly higher than reported in Study 3 (see section 5.3.4). Finally, both the mean score for daily spiritual experience and religious

social support were moderately high and suggested some degree of frequency in experiencing daily religious/spiritual emotion and adequate perceived access to religious social support.

Table 25.

Means and standard deviations for the main predictor and outcome variables

	M	SD
Grief	28.81	14.92
Depression	5.14	4.15
Anxiety	7.20	5.13
Perception of financial situation	2.77	0.93
Social support	64.73	22.58
Physical health	75.78	23.17
Attachment avoidance	13.23	3.95
Attachment anxiety	15.77	4.39
Perceived helpfulness of funeral service	4.25	0.80
Secular bereavement activities/rituals	3.61	0.89
Attendance at religious services	2.41	1.22
Frequency of prayer	3.85	2.15
Spiritual capital	2.07	1.37
Religious/spiritual belief	48.49	19.67
Importance of religious ritual	93.24	34.89
Daily spiritual experience	16.97	7.86
Religious social support	11.71	2.27

6.3.2 Bivariate Correlations Between Predictor and Outcome Variables

Bivariate correlations were carried out to examine the relationship between each of the independent predictor variables with the outcome variables. Spearman's rho correlations were used as some of the variables were non-normally distributed. These correlations can be seen in Table 26.

Of particular note is that social support had a significant negative correlation with both grief and depression. These results suggest that as social support increases, levels of grief and depression decrease. In contrast, attachment avoidance had a significant positive correlation with grief, while attachment anxiety had a significant positive correlation with depression and anxiety. These results suggest that as insecure attachment avoidance increases so does level of grief, while as insecure attachment anxiety increases so do levels of depression and anxiety. Interestingly, perceived helpfulness of the funeral service had a significant negative correlation with grief, depression, and anxiety. These results suggest that as the perception of the funeral service as being helpful increases, levels of grief, depression, and anxiety decrease.

With regard to the religious variables, frequency of attendance at religious services, frequency of prayer, and religious/spiritual belief all had significant negative correlations with grief. These results suggest that as frequency of service attendance, prayer, and strength of religious/spiritual belief increase, the level of grief decreases. In addition, importance of religious ritual had a significant negative correlation with both grief and depression. These results suggest that as the importance of religious ritual increases, levels of grief and depression decrease. Finally, daily spiritual experience had a significant negative correlation with anxiety. This result suggests that as the frequency of daily spiritual emotional experiences increase, levels of anxiety decrease.

Table 26.

Correlation coefficients (Spearman's rho) for each predictor variable with grief, depression, and anxiety

	Grief	Depression	Anxiety
Time since bereavement	-0.06	-0.07	-0.01
Age	-0.16	-0.12	-0.17
Gender	0.13	0.05	0.15
Perception of financial situation	0.06	-0.13	0.02
Social support	-0.25**	-0.20*	-0.11
Physical health	0.03	-0.10	0.11
Attachment avoidance	0.27**	0.16	0.17
Attachment anxiety	0.14	0.28**	0.36***
Perceived helpfulness of funeral service	-0.20*	-0.32**	-0.26**
Secular bereavement activities/rituals	0.06	-0.02	0.02
Attendance at religious services	-0.20*	-0.06	-0.03
Frequency of prayer	-0.21*	-0.13	-0.09
Spiritual capital	-0.17	-0.15	-0.01
Religious/spiritual belief	-0.19*	-0.08	0.11
Importance of religious ritual	-0.26**	-0.20*	0.05
Daily spiritual experience	-0.12	-0.10	-0.19*
Religious social support	-0.09	-0.15	-0.09

* $p < 0.05$; ** $p < 0.01$; ***$p < 0.001$.

6.3.3 Hierarchical Multiple Regression Analyses for Grief, Depression, and Anxiety

Three hierarchical multiple regression analyses were carried out to investigate the influence of important religious variables in predicting grief, depression, and anxiety, in comparison with one another and in the context of influential secular and socio-demographic variables. For the first multiple regression analysis grief was the outcome variable, for the second analysis depression was the outcome, and for the third anxiety. For each multiple regression the independent predictor variables were entered in hierarchical blocks, in the following order: socio-demographic variables, influential secular variables, hypothesised influential secular variables, and religious variables. Only predictor variables that had a significant correlation with the dependent variable were entered into each multiple regression analysis. In addition, guided by previous analyses that included entering all predictor variables, the final block for each multiple regression involved entering interaction terms between age and gender with each of the significant predictor variables within that analysis.

The choice of blocks and predictors was influenced by the theoretical literature on bereavement and personal beliefs (see Chapters 1 and 2), by previous personal beliefs research using multiple regression statistical techniques (e.g. Aflakseir & Coleman, 2009; Fry, 2001; Kirby, Coleman, & Daley, 2004), and by theoretical guides to using multiple regression analysis by Howitt and Cramer (2001), Field (2005), and Pallant (2005). The present approach allowed for known influential factors to be entered early in the regression model and for the influence of hypothesised influential secular and religious variables to be explored in subsequent stages, with the influence of earlier factors being controlled for. The effects of hypothesised influential secular and religious variables could then be investigated at both the level of the amount of variance in the outcome variables accounted for by each block and at the specific level of how influential individual predictors were in predicting each outcome variable. Tables 27, 28 and 29 show the results for the hierarchical regression analyses for grief, depression, and anxiety, and present the unstandardised b-value (B), standard error (SE B), and standardised beta (β) regression coefficients for each predictor variable. The R^2 statistic details the cumulative amount of variance in the outcome variable accounted for by each new block of predictors.

6.3.3.1 Multiple Regression Analysis for Grief

Table 27 shows that with grief as the outcome variable the first block entered into the regression model involving the known influential secular variable of social support accounted for a significant 6% amount of the variance in grief, $R^2 = 0.06$, $F(1, 103) = 7.08$, $p<0.01$. Furthermore, social support was a significant predictor of reduced grief ($\beta = -0.25$, $p<0.01$). The second block entered involving hypothesised influential secular variables accounted for a further significant increase of 7% in the variance of grief, $R^2 = 0.13$, $F(2, 101) = 4.01$, $p<0.05$, with perceived helpfulness of the funeral service being a significant predictor of reduced grief ($\beta = -0.20$, $p<0.05$). The third block involving religious variables accounted for a further increase of 7% in the variance of grief $R^2 = 0.20$, $F(4, 97) = 2.08$, $p>0.05$. Of the religious variables entered only importance of religious ritual was a significant predictor of reduced grief ($\beta = -0.34$, $p<0.05$). The final block involving interaction terms between age and gender and each of the predictor variables accounted for a further 9% of the variance in grief, however this increase did not reach statistical significance $R^2 = 0.29$, $F(14, 83) = 0.74$, $p>0.05$, and no individual interaction predictors reached significance.

Table 27. Hierarchical regression analysis for grief entering known influential secular, hypothesised influential secular, and religious variables, and interactions with age and gender.

Predictor variables	B	SE B	β
Step 1: Known influential secular variables			
Social Support	-0.16	0.06	-0.25**
R^2: 0.06**			
Step 2: Hypothesised influential secular variables			
Social Support	-0.13	0.07	-0.19
Attachment avoidance	0.57	0.40	0.15
Perceived helpfulness of funeral service	-3.81	1.74	-0.20*
R^2: 0.13*			
Step 3:Religious variables			
Social support	-0.12	0.07	-0.19
Attachment avoidance	0.55	0.41	0.14
Perceived helpfulness of funeral service	-3.38	1.82	-0.18
Frequency of attendance at religious services	-0.34	1.41	-0.02
Frequency of prayer	-0.07	1.05	-0.01
Religious/spiritual belief	0.11	0.13	0.15
Importance of religious ritual	-0.14	0.06	-0.34*
R^2: 0.20			
Step 4: Interactions			
Social support	0.22	0.66	0.33
Attachment avoidance	0.73	3.50	0.19
Perceived helpfulness of funeral service	-4.78	1.64	-0.25
Frequency of attendance at religious services	4.86	1.59	0.39
Frequency of prayer	-3.98	1.09	-0.57
Religious/spiritual belief	1.46	1.35	1.92
Importance of religious ritual	-0.89	0.56	-2.09
Age x Social Support	0.00	0.00	-0.09
Age x Attachment avoidance	-0.00	0.04	-0.14
Age x Perceived helpfulness of funeral service	0.00	0.20	0.00
Age x Frequency of attendance at religious services	-0.08	0.20	-0.46
Age x Frequency of prayer	0.11	0.12	1.17
Age x Religious/spiritual belief	-0.02	0.01	-1.91
Age x Importance of religious ritual	0.00	0.00	1.14
Gender x Social Support	-0.16	0.14	-0.53
Gender x Attachment avoidance	0.20	0.79	0.12
Gender x Perceived helpfulness of funeral service	1.42	3.84	0.21
Gender x Frequency of attendance at religious services	0.07	3.89	0.01
Gender x Frequency of prayer	-2.00	2.70	-0.56
Gender x Religious/spiritual belief	0.01	0.32	0.04
Gender x Importance of religious ritual	0.14	0.18	0.73
R^2: 0.29			

$p < 0.05$; ** $p < 0.01$.

6.3.3.2 Multiple Regression Analysis for Depression

Table 28 shows that with depression as the outcome variable the first block entered into the regression model involving the known influential secular variable of social support accounted for a significant 5% of the variance in depression, $R^2 = 0.05$, $F(1, 101) = 5.29$, $p<0.05$. Furthermore, social support was a significant predictor of reduced depression ($\beta = -0.22$, $p<0.05$). The second block entered involving hypothesised influential secular variables accounted for a large significant increase of 19% of the variance in depression $R^2 = 0.24$, $F(2, 99) = 12.41$, $p<0.001$. Within this block the variable of attachment anxiety was a significant predictor of increased depression ($\beta = 0.25$, $p<0.01$), while perceived helpfulness of the funeral service was a strong predictor of reduced depression ($\beta = -0.33$, $p<0.001$). The third block involving the religious variable of importance of religious ritual accounted for a further significant increase of 4% in the variance in depression $R^2 = 0.28$, $F(1, 98) = 6.61$, $p<0.05$. Furthermore, importance of religious ritual was a significant predictor of reduced depression ($\beta = -0.22$, $p<0.05$). The final block involving interaction terms between age and gender and each of the predictor variables accounted for a further 5% of the variability in depression, however this increase did not reach statistical significance $R^2 = 0.33$, $F(8, 90) = 0.85$, $p>0.05$, and no individual interaction predictors reached significance.

Table 28. Hierarchical regression analysis for depression entering known influential secular, hypothesised influential secular, and religious variables, and interactions with age and gender.

Predictor variables	B	SE B	β
Step 1: Known influential secular variables			
Social support	-0.04	0.01	-0.22*
R^2: 0.05*			
Step 2: Hypothesised influential secular variables			
Social support	-0.03	0.01	-0.20*
Attachment anxiety	0.24	0.08	0.25**
Perceived helpfulness of funeral service	-1.73	0.45	-0.33***
R^2: 0.24***			
Step 3:Religious variables			
Social support	-0.03	0.01	-0.18*
Attachment anxiety	0.28	0.08	0.30**
Perceived helpfulness of funeral service	-1.51	0.44	-0.29**
Importance of religious ritual	-0.02	0.01	-0.22*
R^2: 0.28*			
Step 4: Interactions			
Social support	0.17	0.14	0.93
Attachment anxiety	0.40	0.83	0.42
Perceived helpfulness of funeral service	-6.74	3.69	-1.31
Importance of religious ritual	0.10	0.12	0.89
Age x Social support	-0.00	0.00	-1.02
Age x Attachment anxiety	-0.00	0.01	-0.36
Age x Perceived helpfulness of funeral service	0.07	0.04	1.31
Age x Importance of religious ritual	-0.00	0.00	-0.99
Gender x Social support	-0.01	0.03	-0.13
Gender x Attachment anxiety	0.13	0.17	0.32
Gender x Perceived helpfulness of funeral service	0.04	0.73	0.02
Gender x Importance of religious ritual	-0.01	0.02	-0.18
R^2: 0.33			

* $p < 0.05$; ** $p < 0.01$; ***$p < 0.001$.

6.3.3.3 Multiple Regression Analysis for Anxiety

Table 29 shows that with anxiety as the outcome variable the first block entered into the regression model involving hypothesised influential secular variables accounted for a significant 19% of the variance in anxiety, $R^2 = 0.19$, $F(2, 100) = 12.24$, $p<0.001$. Furthermore, within this block, attachment anxiety ($\beta = 0.34$, $p<0.001$) was a significant strong predictor of increased anxiety, while perceived helpfulness of the funeral service ($\beta = -0.26$, $p<0.01$) was a significant predictor of reduced anxiety. The second block entered involving the religious variable of daily spiritual experience accounted for a further 4% significant increase in the variance of anxiety $R^2 = 0.23$, $F(1, 99) = 5.45$, $p<0.05$. Furthermore, daily spiritual experience was a significant predictor of reduced anxiety ($\beta = -0.20$, $p<0.05$). The third and final block involving interaction terms between age and gender and each of the predictor variables accounted for a further 6% of the variability in anxiety, however this increase did not reach statistical significance $R^2 = 0.29$, $F(6, 93) = 1.14$, $p>0.05$, and no individual interaction predictors reached significance.

Table 29. Hierarchical regression analysis for anxiety entering hypothesised influential secular and religious variables, and interactions with age and gender.

Predictor variables	B	SE B	β
Step 1: Hypothesised influential secular variables			
Attachment anxiety	0.39	0.10	0.34***
Perceived helpfulness of funeral service	-1.66	0.56	-0.26**
R^2: 0.19***			
Step 2: Religious variables			
Attachment anxiety	0.39	0.10	0.33***
Perceived helpfulness of funeral service	-1.51	0.55	-0.24**
Daily spiritual experience	-0.13	0.05	-0.20*
R^2: 0.23*			
Step 3: Interactions			
Attachment anxiety	0.28	0.99	0.23
Perceived helpfulness of funeral service	0.56	3.79	0.09
Daily spiritual experience	-0.27	0.61	-0.42
Age x Attachment anxiety	0.00	0.01	0.33
Age x Perceived helpfulness of funeral service	-0.05	0.04	-0.72
Age x Daily spiritual experience	0.00	0.00	0.29
Gender x Attachment anxiety	-0.10	0.20	-0.20
Gender x Perceived helpfulness of funeral service	0.97	0.92	0.43
Gender x Daily spiritual experience	-0.03	0.16	-0.12
R^2: 0.29			

* $p < 0.05$; ** $p < 0.01$; ***$p < 0.001$.

6.4 Discussion

The purpose of the present study was to examine the influence of religious ritual alongside a range of other competing religious variables in predicting grief, depression, and anxiety, in the context of influential secular and socio-demographic variables in older adults who had experienced recent spousal bereavement. In addition, the present study also provided the opportunity to investigate the influence of secular variables such as attachment style, usefulness of bereavement activities/rituals, and perceived helpfulness of the funeral service, that have up until now not been fully examined in the existing body of empirical research.

6.4.1 Influence of Religious Variables

The results showed that when influential secular variables were controlled, including potential personality traits such as adult attachment style, religious variables such as importance of religious ritual and daily spiritual experience still had the ability to account for unique and independent variance in post-bereavement related depression, and anxiety. Of particular note was that importance of religious ritual emerged as a significant independent predictor of grief and depression, with higher levels of importance of religious ritual predicting reduced grief and depression. These results suggest that religious ritual may well be used as a method of religious coping and may indeed possess therapeutic properties that are experienced as beneficial by bereaved older adults.

Amongst the potential therapeutic properties is that religious rituals can provide a sense of closeness to one's spouse that may be experienced as comforting and can facilitate a continuing of the cognitive and emotional bond or relationship felt toward the deceased. In addition, a distinctive characteristic of grief is of physical agitation or restlessness with the bereaved often feeling an urge to act or move and it is here where religious rituals may also be particularly helpful by providing physical outlets for grief or by providing vehicles and activities in which to engage in and express grief-related thoughts or emotions. Religious rituals may also reduce religious, existential, or death-related uncertainties that the experience of bereavement may arouse and that may be unpleasant. Indeed, one significant way that religious rituals may differ from secular bereavement rituals (see below) is in the perceived antiquity of religious rituals, with in some cases rituals being passed down over centuries. The tradition and history associated with religious rituals along with the recognition particularly in older adults that religious rituals have traditionally been used in response to bereavement may make religious rituals appear more valid, legitimate, or useful in relation to grief than secular

bereavement rituals (that may be newly created), thus enhancing their perceived effectiveness or importance. In addition, the present religious ritual findings provide further support for the validity, reliability, and usefulness of the newly developed scale to measure religious ritual.

With regard to daily spiritual experience, this component of religion emerged as a significant predictor of anxiety, with higher levels of experiencing daily religious or spiritual emotions predicting lower levels of anxiety. One explanation for this relationship may be that the increased experience of daily religious/spiritual emotions related to one's faith or the sacred may in different ways be subjectively reassuring and importantly may allay symptoms of anxiety such as one's worries or fears. Alternatively, increased frequency of daily religious/spiritual emotions may prevent one from focusing disproportionately on one's anxieties or from appraising potential stressors or aspects of one's life as anxiety-provoking in the first place. The religious ritual and daily spiritual experience findings lend support for the theorising of Coleman and O'Hanlon (2005) and Fry (2001) who suggest that one way in which religious variables may facilitate coping with bereavement is by buffering or alleviating negative emotional states such as depression and anxiety that are aroused by a significant bereavement.

In addition, in the present study it is perhaps worth mentioning that although spiritual capital did not have a significant correlation with any of the dependent variables, in a previous set of analyses that involved entering all predictor variables in each multiple regression spiritual capital did emerge as a significant predictor of depression, with higher levels of engagement in spiritual capital predicting lower levels of depression. With this in mind, it might be worth exploring the role of engagement in spiritual capital in the context of bereavement in future research, with a particular thought to how engagement in spiritual capital may be beneficial by providing a sense of personal meaning or self-worth that may protect against depression (see Chapter 4).

A disappointing aspect of the present study was that although religious/spiritual belief had a significant negative correlation with grief, it did not emerge as a significant predictor, while religious support failed to correlate with any of the dependent measures. Possible explanations for these findings may be that this was a sample that found religious ritual and emotion more salient to coping than belief or support. Indeed, based on the findings from Study 2 (see Chapter 4), it is not necessarily strength of religious/spiritual belief per se that is important to coping with grief but how belief is used in coping (e.g. in reconstructing meaning).

Future studies may prefer to measure how religious belief is used or how helpful belief is during coping rather than how strong one believes in abstract religious/spiritual concepts.

As for religious support most people seemed to report neither that their perceived support was extremely high or low and this lack of variability may explain why this variable did not correlate highly with the outcome measures. Indeed, half of the items on the religious support scale involved reporting negative interactions with one's religious congregation and British older adults may have been reluctant to be too critical, perhaps because their own sense of identity is associated with their congregation. It is worth noting that the religious support scale was developed in America and as with many other American scales that measure religious variables their validity has been questioned. Many of these scales have been accused of actually tapping into the beliefs of Calvinist Evangelical Christianity and of reflecting the values of American culture (Glicksman, 2007). As such, American scales may not always generalise well outside of North America. Indeed, with so few adequate British religious scales available to measure religious dimensions such as religious belief or support it may well be worth future researchers developing religious scales based solely on and specifically for British samples. This endeavour would prevent future British researchers from being forced to choose between less-than-optimal American scales.

6.4.2 Influence of Secular Variables

With regard to secular variables, the results of the present study showed that when known influential secular variables were controlled the block of new hypothesised influential secular variables accounted for unique and independent variance in grief, depression, and anxiety. Amongst the variables in this block the two that emerged as the strongest predictors were attachment anxiety and perceived helpfulness of the funeral service. Attachment anxiety was a significant predictor of depression and anxiety, with higher levels of insecure anxious attachment predicting increased depression and anxiety. Perceived helpfulness of the funeral service was a significant predictor of all three dependent variables, whereby increased perception of the funeral service as being helpful to coping predicted lower levels of grief, depression, and anxiety.

One interpretation of the present attachment findings is that those with an insecure avoidant attachment style may be at less risk of mental health problems following a significant bereavement than those with an insecure anxious attachment style. Indeed, the present results suggest that those with an insecure anxious attachment style may be at risk of experiencing

increased, or pathological, depression and anxiety. However, this interpretation should be considered with caution as within the present cross-sectional study it is difficult to say whether increased attachment anxiety scores reflected a long term personality trait or whether insecure attachment anxiety scores were inflated as a result of experiencing recent spousal bereavement. Future bereavement research using prospective designs will be able to delineate the influence of attachment anxiety and avoidance on grief and other mental health variables by establishing pre-bereavement levels of adult attachment.

One particularly new and interesting finding was that increased perception of the funeral service as being helpful was a predictor of lower levels of grief, depression, and anxiety. This variable is by far the least theorised of the present predictors within the bereavement literature but suggests that for British older adults the funeral service may be an important factor that influences coping. Indeed, funeral services are often ritualistic in nature with most having a religious theme and therefore this finding is consistent with the results on the influence of importance of religious ritual in the present study. The funeral service may be important to coping because it offers older adults the opportunity to express their final farewell to their spouse after a long marriage or to offer their spouse the funeral service they would have wanted and therefore suggests that it may promote similar therapeutic properties as religious rituals. It would perhaps be prudent for future research to consider carefully the role of the funeral service in coping with bereavement and to explore these findings with different age cohorts.

One disappointing result was that engagement in secular bereavement activities/rituals did not correlate highly with grief, depression, or anxiety. A possible explanation for these findings is that items on the scale by Castle and Phillips (2003) did not generalise well to a sample of British older adults. Indeed, the items on the scale were based on an earlier study of Americans and on the researchers' own clinical experiences, and validated using a younger Californian sample. Furthermore, to the best of the present researcher's knowledge, this is the first time that this scale has not only been used outside of North America but has been used in an inferential statistical study, having previously been validated using mainly descriptive statistics (see Castle & Phillips, 2003). From a methodologically perspective, the response format for the scale is better suited to descriptive statistics and was perhaps not optimal for use with British older adults. The scale involved asking participants to tick grief activities they had engaged in and allowing participants to leave certain items unanswered thus appearing inconsistent with the other scales used in the questionnaire booklet and influencing how the scale is scored. Nevertheless, this scale does possess some insightful and unique items about

coping with bereavement, and using this study as a first step other researchers may wish to further refine this scale in future studies with British samples.

6.4.3 Summary

In summary, the present study provides support for the importance of two new religious variables (i.e. religious ritual, and daily spiritual experience) and two secular variables (i.e. perceived helpfulness of the funeral service, and attachment anxiety) in predicting post-bereavement related grief, depression, and anxiety in older adults who have experienced recent spousal bereavement. The influence of these up until now theoretically overlooked and empirically under-researched variables should be considered carefully in future bereavement or mental health research with older adults.

PART 4

Chapter 7
Advancing a Theoretical Understanding of the Role Played by Religious Belief and Practice in Coping and Adjusting to Spousal Bereavement

7.1 Introduction

The final chapter of this thesis takes the form of an overall general discussion that will review the present research findings and in the process highlight the original contribution made to the existing knowledge base. The discussion will begin by reflecting on and integrating the main religious findings from the present research and will then consider these findings in the context of theories of coping with bereavement. It will then be discussed how the present research advances theoretical understandings about the psychology of religious belief and practice. The discussion will then consider the clinical implications of the research, limitations, and directions for future research.

The present thesis has presented four studies, using both qualitative and quantitative methodologies, to explore and investigate the role of Christian religious belief and practice in British older adults coping and adjusting to spousal bereavement. In the process, the research has attempted to explain how religious belief and practice may exert a potential positive influence on coping, highlighting the cognitive, emotional, and behavioural mechanisms underlying religion's influence.

In thinking about the contribution of the present research, the findings can be thought of as contributing to three separate yet in the present context overlapping areas. The first area is the psychology of religion, second is the clinical area of coping with bereavement, and third is the area of psychogerontology. Apart from the contribution to the area of research at the intersection of these three areas, perhaps the next most significant individual contribution is to the increasing body of mainly American literature on the psychology of religion. The present research has been able to produce and elucidate on a taxonomy of religious-based processes and developed new methods of measuring previously unaddressed religious behaviours. From a psychology of coping with bereavement perspective, the present research provides data on a range of coping factors (i.e. techniques, resources, and traits) that can influence coping and may generalise to other age groups and cross-culturally. Finally, from a psychogerontology perspective, the present research provides further insight into the thought processes, sources of personal meaning, and responses to age-related challenges relevant to contemporary British older adults.

7.2 Reviewing the Main Research Findings

The present research has identified several components of religion that may be experienced as useful or beneficial by British older adults coping and adjusting to spousal bereavement. These components are briefly reviewed below.

In the present research, the religious component that proved to be of primary importance in coping was labelled *benevolent religious cognition*. This component attempted to capture, unify, and represent the religious content and cognition likely to be most important to coping with bereavement amongst those older adults with a strong Christian religious belief. Religious beliefs that were characteristic of benevolent religious cognition and identified in Study 1 and 2 included: belief in a benevolent, omnipresent, omniscient God; belief in a life after death; belief in a life after death reunion; feeling a sense of providence (i.e. the protective care of God); and having confidence in prayer as a method of appealing to God and deceased loved ones (e.g. parents, spouse) for support, protection, or guidance. Importantly, the beliefs that contributed to benevolent religious cognition may differ significantly from items included on questionnaires that measure general strength of religious/spiritual belief, as was used in Study 4. However, the present research also suggests that there may be at least two caveats or conditions that govern whether benevolent religious cognition will be experienced as useful during coping. First, is that benevolent religious cognition will most likely be experienced as effective when it is understood within the context of a coherent (and perhaps long held) belief system; and second, and perhaps more importantly, is that there needs to be certainty in the belief system itself. For moderate believers, weak believers, and perhaps those who turn to religion for the first time following a significant bereavement, benevolent religious cognition may be less useful in coping.

Perhaps the next most important component was labelled *religious ritual* and was identified as important in Study 2 and investigated further in Study 3 and Study 4. Study 3 synthesised from the existing literature on ritual that religious ritual represents the repetitive behaviours or activities involved in the practice of one's religious faith that can symbolically express or communicate the meaningful thoughts, feelings, or values of a religious individual, group, or culture. In the present research, engaging in religious rituals served multiple purposes during coping including: facilitating a psychological and emotional closeness to the deceased; encouraging emotion regulation and catharsis; maintaining a familiar routine during a time of discord; providing a sense of being proactive; and stimulating positive remembrance. In Study 3 after developing the first scale of its kind to measure religious ritual, it was found in Study 4

that high importance of religious ritual in one's life was an independent predictor of lower levels of grief and depression in older adults who had experienced recent spousal bereavement.

Related to religious ritual was the influence of *Biblical assurances* on coping. Biblical assurances was the label used to refer to how participants were able to use a diverse range of Biblical sources (e.g. passages, quotes, stories, themes, metaphors, and characters) to facilitate coping. The primary way that Biblical assurances were helpful to coping was by reinforcing benevolent religious cognition and supporting the use of benevolent religious cognition in meaning-making processes. In addition, Biblical assurances also had the potential to contribute to coping via several other pathways including: helping the bereaved to understand in a more manageable way the complex set of thoughts and emotions aroused by grief; by encouraging positive thoughts and emotions such as hope and optimism to be experienced; by inspiring determination and motivation to cope; and by providing techniques such as repetition of Biblical phrases/sayings that could regulate emotions. In Study 3, an item tapping into the importance of reading religious scripture in one's life was incorporated in the Importance of Religious Ritual scale. Factor analysis techniques revealed that this religious component was grouped with other highly salient religious practices such as attending church services, receiving Communion/the Eucharist, and importance of prayer.

A very different component of religion than one focused on cognitive belief, performing rituals, or drawing on religious scripture, was labelled *spiritual capital*. This component of religious involvement referred to participants' engagement in regular jobs, activities, and roles on behalf of their local community church, separate from their religious practice, that took on added importance following bereavement and influenced coping. Participants were able to integrate their involvement in these activities into a new post-bereavement identity, an identity that encouraged purpose, meaning, and social involvement and buffered against negative aspects of grief such as loneliness, hopelessness, and boredom. Furthermore, through church activities involving interacting with the sick, frail, and less fortunate, participants were more likely to engage in downward social comparisons that could facilitate coping. Participants could come to compare their own circumstances with the circumstances of those considered to be worse off or enduring worse suffering and thus in comparison perceiving their own loss as being less negative. In Study 4, after developing an item to measure spiritual capital, when all predictor variables were entered into analyses, higher frequency of engagement in spiritual capital was identified as an independent predictor of lower levels of depression in older adults who had experienced recent spousal bereavement.

A religious component that was identified in Study 4 as helpful to coping was labelled *daily spiritual experience*. In the present research, daily spiritual experience was used to refer to the emotional component of an individual's religious or spiritual belief, and assessed the frequency of an individual's emotional experience and perception of their belief on a daily basis. This conceptualisation was derived from the theorising of Idler et al. (2003) and was used in the present research as a way to complement religious cognitive belief and religious behaviour and to ensure that religion at the cognitive, behavioural, and emotional levels were present in the research. In Study 4, increased frequency of daily spiritual experience was identified as an independent predictor of lower levels of anxiety in older adults who had experienced recent spousal bereavement. The interpretation of this finding was that increased frequency of experiencing reassuring religious or spiritual emotions on a daily or regular basis may have had the effect of buffering against or allaying any negative grief-related emotions such as worry, panic, or fear.

An additional religious component that received some limited support as a resource in coping was c*hurch-based social support*. This component referred to actual or perceived access to emotional or practical support from members or ministers of one's local church during coping. Although in Study 4 there was no support for a questionnaire measure of church-based social support as having a statistically significant relationship with grief, depression or anxiety, Study 1 suggested that for some highly religious older adults who attend church regularly, the perceived availability of moral, emotional, and practical support was appreciated if seldom required. Based on Study 1, church-based social support may be particularly useful with regard to coping with restoration-oriented stressors when close family members may not be available.

Finally, it is perhaps worth mentioning that in the two qualitative studies the majority of those with a strong Christian belief reported experiencing an increase in the importance of their religious belief and practice following their bereavement. In the present research this observation was labelled *spiritual growth*. In contrast to the experience of bereavement causing those with a strong belief to doubt or question their belief, in different ways the bereavement was interpreted as confirming or reinforcing their religious belief. This aspect is referred to again later in relation to cognitive dissonance.

7.3 Integration of Research Findings within Theories of Coping with Bereavement

In thinking about the bereavement theories reviewed in Chapter 1, the findings from the present research can perhaps best be incorporated within the Dual Process Model (DPM, Stroebe & Schut, 1999, 2001); continuing bonds (Klass, Silverman, & Nickman, 1996); and meaning reconstruction (Gillies & Neimeyer, 2006). To the best of the present author's knowledge the following connections between religion and bereavement theories have not been discussed in the literature. Each of these theories will be considered in turn.

With regard to the DPM, religious belief and practice may be flexible enough to function within both loss-and-restoration-orientations. Religious belief, or more specifically benevolent religious cognition, is perhaps ideally situated to be used in loss-oriented coping. Within this orientation, the death-specific content relevant to benevolent religious cognition can be used or drawn upon within cognitive models of processing the bereavement. These models may use benevolent religious cognition in assimilating and accommodating the bereavement within personally meaningful schemas of understanding the world and also in reappraising and reinterpreting the bereavement in less threatening ways. At the same time, it may also be possible that benevolent religious cognition can be used in restoration oriented coping as a form of avoidance or distraction from the realisation about the finality of the loss within one's present life. Thus, the bereaved may be able to oscillate between using benevolent religious cognition to approach the loss and provide explanation about the bereavement consistent with one's belief system but also in temporary avoidance about the permanence of the loss within one's life.

In thinking about religious practice, religious ritual may also be well-situated to function in both loss-and-restoration-orientations. Religious ritual may be used in loss-oriented coping by providing outlets for grief or vehicles and activities to express emotional needs, used in the regulation of grief-related emotions, and useful in reducing religious or existential uncertainty. Religious ritual may also be used in restoration-oriented coping in providing familiar and reassuring patterns of post-bereavement behaviour as well as providing brief respite from thinking about the loss during the performance of rituals. As such, the bereaved may be able to oscillate between using religious ritual to express their grief or emotional needs but also as a way of avoiding thinking about the loss.

Other components of religion may also be incorporated within the DPM. For example, use of religious scripture as in Biblical assurances may be used in loss-oriented coping through supporting benevolent religious cognition during meaning-making processes but also in

providing literary sources that contribute toward regulating grief emotions, while in restoration-oriented coping religious scripture may offer some avoidance from rumination on the loss. With regard to spiritual capital this component of religion is perhaps ideally situated in restoration-oriented coping. Spiritual capital can be used in reconstructing a new post-bereavement identity of meaning and purpose, and can encourage social involvement that may prevent loneliness or rumination on the loss. Finally, experiencing daily spiritual emotions as conceptualised in daily spiritual experience may play a role in loss-oriented coping. Daily spiritual experiences may alleviate or buffer against grief-related anxiety and similarly to benevolent religious cognition may provide distraction, reassurance, or comfort from the stress caused by restoration changes that may need to be made.

In regard to the theory of continuing bonds, religious ritual perhaps provides one of the most potent and effective methods of maintaining a perceived relationship with a deceased loved one. Findings from Study 1 and 2 revealed that engaging in religious rituals such as attending church services, receiving Communion/Eucharist, and prayer had the potential of encouraging or maintaining a sense of closeness to the deceased. In addition, benevolent religious beliefs such as belief in a life after death, belief in life after death reunion, and belief that deceased loved ones can help the living all contribute toward maintaining a perceived emotional and psychological ongoing relationship with the deceased. This perceived ongoing relationship can then be drawn upon or accessed through belief and ritual as and when needed by the bereaved individual.

Finally, with regard to meaning reconstruction, as identified in Study 2, benevolent religious cognition, Biblical assurances, and spiritual capital can all be involved in the bereaved reconstructing meaning following bereavement. Benevolent religious cognition involving belief about the deceased being in a better, safer place (i.e. heaven) and no longer suffering, and belief about the also religious deceased spouse achieving their spiritual goal of ascending to or entering heaven, could be used in benefit finding. At the same time, benevolent religious belief about the bereavement being part of God's plan for either the deceased or the bereaved, and belief that present suffering is ultimately linked with future compensation in heaven, could be used in sense making. In addition, a wealth of Biblical sources involving assurances about life after death, resurrection, and God's omnipresence and omniscience could support benevolent religious cognition being used in benefit finding and sense making. Finally, with regard to identity change, spiritual capital was a useful resource in helping bereaved older adults to reconstruct a post-bereavement identity of new meaning, purpose, and social involvement.

In summary, when the present research findings are considered across and within the DPM, continuing bonds, and meaning reconstruction, the process of oscillation within the DPM may be a key factor involved in optimal coping. Bereaved older adults with a strong religious belief may be able to oscillate between using religious and secular resources (e.g. family), between using religious belief and religious ritual, between using religious resources to approach and avoid thinking about the loss, and between using religion to focus on meaning reconstruction and continuing bonds. An alternative way of expressing the present findings is that religious belief in the form of benevolent religious cognition is primarily involved in cognitive meaning-making about the bereavement, and supported by Biblical assurances, while religious ritual is primarily involved in regulating grief-related emotion, and may be influenced by the experience of daily spiritual experiences. Finally, during coping, when religious belief or practice is used or drawn upon and is experienced as useful, religion as a coping resource may become reinforced and is thus more likely to be continually drawn upon or utilised when faced with future challenges.

7.4 Forwarding a Psychological Understanding of Religious Belief and Practice: Sources of Difference

During the course of the present research, through interviewing older adults about their religious belief and practice, a number of differences could be observed in how participants described their religious beliefs. Bearing in mind differences in older adults' abilities to articulate their religious/spiritual beliefs which can be an ineffable subject at the best of times, and differences in life experiences and education, and differential ageing, these observed differences are suggested speculatively rather than definitively. However, for researchers planning on conducting future research with religious older adults some of these observations may be useful as they may influence what designs and measures are selected in research. These differences can be classified into two main categories: 1) differences in religious belief style; and 2) sources of difference within and between religious believers.

Differences in belief style refers to the observation that some religious older adults expressed a religious belief that could be described as a complex belief style, while others expressed a religious belief that was far less complex and could be described as a simple or straightforward belief style. The characteristics of a *complex belief style* involve a belief that is supported by a rich and detailed understanding of Christianity and denominational practice from which breadth and depth of knowledge about one's belief system can be drawn upon. In addition, those with a complex belief style may be more likely to spend time thinking about

their beliefs, practices, and experiences; may be more likely to pay close attention to specific details of their belief and practice; and may be more inclined to learn new things about their belief. In contrast, is a *simple/straightforward belief style* that involves a belief that is supported only by the key, fundamental principles of Christianity, and a more flexible approach to doctrine. Additional characteristics of this belief style may include less apparent, active pondering about the details of one's belief, practice, and experience; little need to elaborate on the details of one's belief and practice; and little need for additional information about one's belief system in order to maintain a belief.

Drawing on theory within personality psychology to provide possible explanation for this difference in styles, an underlying characteristic that might differentiate a complex belief style from a simple/straightforward belief style is the personality trait known as *need for cognition*. The definition of need for cognition is "the need to think about and impose meaningful structure on one's experiences" (Carver & Scheier, 2000, p.257). According to Carver and Scheier (2000), people high in need for cognition are often inclined to evaluate and process in more depth the details of an argument, idea, or belief before it is accepted, while those lower in need for cognition may be more inclined to accept a proposition presented to them at face value. Based on this explanation, it could be argued that those with a complex belief style perhaps need more supportive detail, structure, and rationale to their belief and practice before it can be accepted and embraced, while those with a simple/straightforward belief style may be more inclined to accept their belief as it is presented to them with a minimum of supportive explanation or justification. One implication of this observation is that although in quantitative research on many measures of general strength of religious/spiritual belief there may appear to be no differences between those with a complex and simple/straightforward belief style, there may be significant latent differences in the underlying cognitive architecture supporting the religious belief.

With regard to sources of difference within and between religious believers three categories can be identified that are worth considering: 1) intra-individual differences; 2) inter-individual differences; and 3) inter-denominational differences. Intra-individual differences refer to differences in emphasis or importance placed on different components of religion within an individual. Inter-individual differences refer to how even people within the same denomination may place different emphasis or importance on different components of religion. Finally, inter-denominational differences refer to how different Christian denominations (and perhaps even the same denominations located in different geographic areas) may place different

emphasis or importance on different components of religion. Thus, in summary, there may be important variations in the use of religion in both coping and non-coping contexts amongst those classified as Christians and many of these variations may not be accessible by quantitative methods alone.

7.5 Clinical Implications

One of the growing trends in the American psychology of religion literature has been to consider, and in some cases apply, the health and well-being benefits associated with religion and spirituality to the clinical practice of medicine, clinical and counselling psychology, and psychotherapy. This application of the research findings is leading to increasing numbers of American physicians, therapists, and counsellors being trained or encouraged to take a more holistic perspective of their patients and clients, with sensitivity to the spiritual as well as psychological and physical needs/concerns of the people they treat. Furthermore, there is a growing recognition that the religious/spiritual worldviews of patients and clients are likely to influence medical model illness explanations and treatment expectations. It is perhaps from this more holistic perspective that the present findings will be at their most far reaching.

More specifically, the present findings have a number of potential implications for therapists and counsellors working with or treating bereaved clients. According to Clarke, Hayslip, Edmondson, and Guarnaccia (2003), those treating the bereaved should not only understand grief reactions in terms of loss or the circumstances of loss but also in terms of accompanying religious beliefs. Indeed, therapists and counsellors should perhaps enquire about the personal belief systems of all their clients, and assess belief systems for any death-related content likely to be used in meaning-making, and establish whether a belief system is coherent and likely to be supportive during coping.

With regard to those with a strong religious belief, the present research suggests that it is important that therapists and counsellors understand their clients' religious beliefs and the influence they may have on how death is reappraised, made sense of, and accepted. In addition, therapists and counsellors should be mindful of how the emotional needs of those with a strong religious belief can be expressed physically through religious ritual, while complex grief-related thought processes may be understood and expressed in a simpler form through Biblical literary techniques (e.g. metaphor, simile) and symbolism. The present findings cautiously suggest that therapists and counsellors may wish to enhance the progress of religious clients by encouraging a focus on or discussion about benevolent religious cognition that may encourage

religious clients in sense making and benefit finding and may contribute toward cognitive acceptance. In addition, therapists and counsellors may also wish to enquire about how often those with a strong religious belief experience religious/spiritual emotions and whether these experiences bring momentary respite from grief, reassurance, or allay any anxiety-provoking thoughts.

A further implication concerns findings related to spiritual capital and may be most relevant to church organisations and religious ministers. In the qualitative research, many older adults reported positive post-bereavement identity change related to having meaningful roles and jobs working on behalf of the church. It may be helpful for religious clergy or those who minister or provide pastoral care to bereaved older adults to consider offering suitable roles within the church to those older adults whose coping may benefit from the sense of meaning and purpose that can be derived from spiritual capital.

The findings also have relevance for gerontologists with an interest in religion. Existing research suggests that the importance of religious belief and practice can change with age. In older age there can be a reduction in church attendance due to declines in physical health, finances, or access to transport, leading to more time spent in private religious practice and as a result an increase in importance of or reliance on the content of religious beliefs (Clarke, et al. 2003; Idler & Kasl, 1992). The present research contributes toward a better understanding of what the most important content of religious beliefs may be to older adults experiencing age-related declines or losses.

In thinking about those without a strong religious belief, therapists and counsellors should establish whether their clients have any personal belief system that is likely to be used as a framework of meaning and explanation with regard to bereavement. For example, if clients have a moderate religious belief there may be variations in belief in God or life after death used in coping, but there may also be an inclination to draw on other beliefs in latent acceptance such as attributions to fate. In the case of those with no religious or spiritual belief it should be established whether clients have a coherent secular, atheistic, or other philosophy of life belief and how this belief orientation is likely to influence coping.

Other factors identified in the present research that therapists and counsellors may find worthwhile investigating is about the role played by their client within their family structure and whether clients can openly express their grief in the presence of close family. Therapists and counsellors should also enquire about their client's daily routines and about what activities bring respite from grief and what activities encourage positive thoughts and emotions. Other

areas of enquiry may involve assessing any present or past history of insecure attachment anxiety. More generally, it may be useful to establish whether clients are able to engage in benefit finding, downward social comparisons, and whether they found the funeral service helpful or not. Many of these non-religious factors could be ethically and easily enquired about within therapy sessions.

Returning again to the possible inclusion of discussion about religion or spirituality within treatment programs or therapy sessions a word of caution should be highlighted as there are likely to be many ethical issues that would need to be resolved. One particular issue worthy of mention is related to the perceived power imbalance during therapy sessions. Many may be concerned that the therapist/counsellor in a position of authority and influence may deliberately or inadvertently respond judgementally or in a proselytising way in response to a client's personal beliefs that may not be in the best interests, or may even be harmful, to the client who may be impressionable and in a position of vulnerability. Potential safeguards to protect the well-being of clients could include therapists/counsellors being non-judgemental and monitoring their neutrality during discussions about the client's personal beliefs, and perhaps an informed consent component before therapy begins confirming that the client is happy to discuss any personal beliefs and practices that may be relevant to treatment. Finally, if religious or spiritual beliefs or practices were to be incorporated within any ongoing treatment, then therapists and counsellors would need to monitor carefully that clients were able to use both religious/spiritual resources and secular resources, and that clients did not become fixated on one resource at the expense of the other.

7.6 Limitations

In considering the present research findings a number of limitations should be addressed. As has been discussed by a number of researchers (e.g. Coleman et al. 2007; Speck et al. 2005; Stroebe, Stroebe, & Schut, 2003), those who volunteer to participate in bereavement research are perhaps unlikely to be representative of the wider population of bereaved persons. Indeed, participants may have their own agendas for participating, including receiving some kind of therapeutic benefit from the experience. Within bereavement research it still remains unclear whether those who do participate are more or less distressed than those who decline. However, research by Stroebe and Stroebe (1989) suggests that there is no difference in depression, a marker of distress, between those who do participate in research and those who refuse. In the present research refusal rates could not be ascertained, however during

the qualitative studies motives stated for participating were similar to those given in similar research (e.g. Coleman et al. 2007), namely: "to help others" and "to increase awareness about bereavement". With regards to recruitment of participants, the present research had a number of strengths, for instance, geographically, participants were recruited widely; participants were from a range of socio-demographic backgrounds; and apart from in Study 1, few if any had participated in bereavement research before. Furthermore, in the context of bereavement research where recruitment of bereaved older adults can be challenging, relatively large samples were recruited.

A different limitation is related to the research designs used. Although cross-sectional and retrospective designs are frequently used in bereavement and personal beliefs research, use of these designs provide little information about the content and function of participant religious belief and practice prior to bereavement. Certainly in cross-sectional designs it is difficult to determine the temporal order of events and whether the experience of grief influenced a change in religious belief and practice. Indeed, future research should examine the prevalence of cognitive dissonance in religious belief and practice following bereavement. It is possible that for some people with a strong religious belief the experience of bereavement causes an inconsistency in beliefs leading to a state of internal tension and a motivation to change or modify these inconsistent beliefs to reduce dissonance. Indeed, reports of spiritual growth and increased importance of religious belief and practice could be interpreted as one such example of cognitive dissonance at work. Such participants may change their attitude toward their belief and practice in the only way they can to preserve and protect an important system of belief in the light of an event that might otherwise threaten the belief system. Future research using prospective designs that measure the content and function of religious belief and practice before and after a significant bereavement will be able to examine the extent of cognitive dissonance.

Finally, with regard to the retrospective designs used in the two qualitative studies, caution should be taken in the accuracy of participant accounts of coping. It should also be remembered that material recalled during interviews can be influenced by the present emotional state of the participant. However, due to the robustness and reoccurrence in religious content and practice reported as helpful, there is some confidence that these studies accurately captured the religious content and practice most likely to be involved in coping with spousal bereavement. One advantage of using a retrospective design, and specifically in the context of Study 2, is based on the fact that processes such as sense making, benefit finding, and identity

change, can appear many years after bereavement and therefore a retrospective design should have been able to tap into these processes.

7.7 Directions for Future Research

In thinking about directions for future research a number of potential studies are suggested. The present research has explored the positive influence of religion on coping, but a useful complementary approach would be to examine the potential negative influences of religion on coping. A potential starting point would be to examine the extent of malevolent religious cognition following bereavement, for example believing that God is vengeful, or that one's bereavement is a punishment from God. Other avenues might involve identifying whether religious inspired continuing bonds can become maladaptive and inhibit a return to normal daily functioning, whether engagement in ritual behaviour can become obsessive and dogmatic, and whether religious involvement can prolong negative mood states. Indeed, for some people, attending church after a significant bereavement can be an emotionally painful experience and some may express anger toward God or the notion of a God. How these potential negative experiences of religion influence coping should all be explored as well as examples of loss of faith following bereavement as identified by Coleman, Ivani-Chalian, and Robinson (2004) and whether this can lead to poorer coping.

Another area of research would be to examine whether maturity of religious belief or the length of time with which a belief has been held is an additional factor involved in coping. In the present qualitative research all of the older adults expressed having a religious belief since at least young adulthood, however it would be interesting to conduct similar research with older adults who have held a religious belief for varying durations, especially those who have turned to Christianity for the first time in later life. Similarly, it would be interesting to investigate the use of religion by older adults in comparison with equally religious younger adults and to identify any variations in coping after controlling for age-related differences.

At a more fundamental level, more research should investigate how British older adults as well as middle-aged and younger adults define and describe religion and spirituality, and the relationship between these concepts. Although the present research suggests that many older adults consider themselves as both religious and spiritual, surprisingly little research has explored how British older adults themselves define spirituality and what spirituality means to them (see also Sadler & Biggs, 2006). Within the social scientific literature there are a myriad of definitions and interpretations of spirituality and many researchers may choose definitions

and understandings based on what spirituality means to them rather than what spirituality means to their participants. In a society that is moving toward more religious/spiritual pluralism, flexibility, and individual choice, understanding more clearly how different generations define religion and spirituality will provide insight into how these potential coping resources may be used by future generations of older adults. This information will also help other researchers to select the most appropriate definitions of spirituality for their sample.

Finally, to further complement the present research it would be well-worth exploring the role played by an explicitly atheistic belief system in coping with bereavement. Indeed, some recent case study research by Wilkinson and Coleman (2010) suggests that a strong atheistic belief may be as helpful as a strong religious belief in coping with bereavement. Drawing on the theorising of Dawkins (2006), Wilkinson and Coleman (2010) suggest that an atheistic belief system through the processes of providing support, explanation, consolation, and inspiration may function similarly to a strong religious belief system. A first step in exploring the influence of a strong atheistic belief system on coping with bereavement may be to examine the functions of these hypothesised processes in the context of late life bereavement.

7.8 Conclusion

As stated by Wortmann and Park (2008) it has long been assumed that religion is helpful to coping with bereavement. However, the explanations for why religion might be helpful have tended to lack sufficient detail to be accepted as entirely satisfying. The present research has attempted to understand from a psychological perspective how religion may exert an influence on coping and adjustment in the context of British older adults who have experienced spousal bereavement. The present research has attempted to be sensitive to the religious content, behaviour, emotion, and support involved in coping and tap into the underlying psychological processes and mechanisms that account for religion's influence.

Based on the present research, the use of religion in coping is more specific than just general religious belief or general religious practice, specific Christian beliefs captured by benevolent religious cognition, and specific Christian religious rituals are innovatively applied to specific experiences of grief. For religious older adults, although the application of their belief to coping with their grief seems necessary in order for their religion to be experienced as useful in coping, it may not be sufficient. Indeed, in addition to belief, practice elements such as religious rituals and Biblical assurances may also be important, perhaps even more important than religious belief or faith alone, because during times of crisis these practice elements make

cognitive belief or faith as an abstract concept that resides in the mind, concrete, tangible, observable, and usable, in a word - real. In this way religious belief and the functions that religious practice can provide can be actively used to cope with grief at the cognitive, emotional, and behavioural levels, with varying degrees of success during the coping process.

However, the role of religion should not be overestimated. Indeed, there may be religious older adults who are unable to find solace in their religion or are unable to apply their belief and practice to their experience of grief. Furthermore, in a culture such as in Britain whereby successive generations are becoming increasingly more secular and sceptical of religion, the use of Christian religious belief and practice in coping may become less and less as each new generation enters older age. In addition, it should be remembered that religion is but one resource amongst many factors, and that religion is unlikely to be used in isolation. Coping may involve other salient factors such as health status, personality, past experiences, relationships with family and friends, age at time of bereavement, the pre-bereavement relationship with the spouse, and the circumstances of the death. However, for individuals with a strong, certain, coherent Christian religious belief, religion is one extra resource that religious older adults unlike non-religious older adults (without a coherent secular belief), may have access to during coping.

APPENDICES

Appendix A: Example of Study 1 Informed Consent Form

A Follow-Up Study of Personal Beliefs and Spousal Bereavement

Consent Form for Research Participants

Information sheet

I am John Spreadbury a postgraduate research student in the health psychology research group at the University of Southampton. I am requesting your participation in a study regarding the role of personal beliefs in the bereavement process. This will involve an interview where I would like you to tell me about your experiences of accepting, adjusting and coping with bereavement from your spouse during the intervening years since the time you were last interviewed. I have some fairly general questions about your personal beliefs be they religious, spiritual, or philosophy of life, the influence you feel your beliefs may have had in helping you adjust, cope and give meaning to life, and whether you feel your beliefs have changed since we last spoke to you. I would also like you to complete again a copy of the Bereavement Experience questionnaire that you completed originally when previously interviewed. The interview will probably take about 60 minutes of your time and will be tape recorded for later transcription. Personal information will not be released to or viewed by anyone other than researchers involved in this project and all tapes will be destroyed immediately after transcription. Results of this study will not include your name or any other identifying characteristics.

Your participation is voluntary and you may withdraw your participation at any time. If you have any questions please ask them now, or contact me, John Spreadbury at the University of Southampton by telephone on (*details omitted*) or by email on Jhs101@soton.ac.uk. Or by contacting Professor Peter Coleman by telephone on (*details omitted*) or by email on P.G.Coleman@soton.ac.uk.

Signature Date
Name John Henry Spreadbury

Statement of Consent

I _____ have read the above informed consent form.
[participants name]

I understand that I may withdraw my consent and discontinue participation at any time without penalty or loss of benefit to myself. I understand that data collected as part of this research project will be treated confidentially, and that published results of this research project will maintain my confidentiality. In signing this consent letter, I am not waiving my legal claims, rights, or remedies. A copy of this consent letter will be offered to me.

(Circle Yes or No)

I give consent to participate in the above study.	Yes	No
I give consent to be audio taped.	Yes	No
I understand that these audio tapes will be destroyed after analysis	Yes	No

Signature Date
Name *[participants name]*

I understand that if I have questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I can contact the Chair of the Ethics Committee, School of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 3995.

Appendix B: Example of Study 1 Debriefing Form

A Follow-Up Study of Personal Beliefs and Spousal Bereavement

Debriefing Statement

The aim of this research was to investigate the influence of personal beliefs, be they religious, spiritual, or philosophy of life, on adjustment, coping, and meaning making following bereavement in later life. We hope to examine the role played by these personal beliefs in the post-bereavement process and to see in what ways these beliefs may have changed with time and experience. It is expected that participant personal beliefs will have been instrumental and integral to adjustment, coping and meaning making during the intervening years and that participant beliefs will have remained stable with time. Your data will help our understanding of how the personal beliefs of older adults are used in adjusting and coping with bereavement in the years following the loss of a spouse.

Once again results of this study will not include your name or any other identifying characteristics. The research did not use deception. You may have a copy of this summary if you wish. You may also have a summary of the research findings once this project is completed.

If you have any further questions please contact me, John Spreadbury, at the University of Southampton, School of Psychology, by telephone on (*details omitted*) or by email on Jhs101@soton.ac.uk. Or by contacting Professor Peter Coleman by telephone on (*details omitted*) or by email on P.G.Coleman@soton.ac.uk. If you would like to talk to a trained counsellor about your bereavement please contact Dr (*details omitted*) by email on (*details omitted*)@soton.ac.uk or by telephone on (*details omitted*).

Thank you for your participation in this research.

Signature _____ Date _____

Name

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 3995.

Appendix C: Example of Geriatric Depression Scale (GDS)

For each item, please circle the best answer (**Yes or No**) for how you felt over the **past week**.

1	Are you basically satisfied with your life?	Yes	No
2	Have you dropped many of your activities and interests?	Yes	No
3	Do you feel that your life is empty?	Yes	No
4	Do you often get bored?	Yes	No
5	Are you in good spirits most of the time?	Yes	No
6	Are you afraid that something bad is going to happen to you?	Yes	No
7	Do you feel happy most of the time?	Yes	No
8	Do you often feel helpless?	Yes	No
9	Do you prefer to stay at home, rather than going out and doing new things?	Yes	No
10	Do you feel you have more problems with memory than most?	Yes	No
11	Do you think it is wonderful to be alive?	Yes	No
12	Do you feel pretty worthless the way you are now?	Yes	No
13	Do you feel full of energy?	Yes	No
14	Do you feel that your situation is hopeless?	Yes	No
15	Do you think that most people are better off than you are?	Yes	No

Appendix D: Example of Personal Meaning Index (PMI)

Personal Meaning Index

This questionnaire contains a number of statements related to opinions and feelings about yourself and life in general. Read each statement carefully, and then indicate the extent to which you agree or disagree by circling one of the alternative categories provided. For example, if you strongly agree, circle SA following the statement. If you moderately disagree, circle MD. If you are undecided, circle U. Try to use the undecided category sparingly.

SA	**A**	**MA**	**U**	**MD**	**D**	**SD**
Strongly Agree	Agree	Moderately Agree	Undecided	Moderately Disagree	Disagree	Strongly Disagree

1	My past achievements have given my life meaning and purpose.	SA A MA U MD D SD
2	In my life I have very clear goals and aims.	SA A MA U MD D SD
3	I have discovered a satisfying life purpose.	SA A MA U MD D SD
4	The meaning of life is evident in the world around us.	SA A MA U MD D SD
5	I have been aware of an all powerful and consuming purpose towards which my life has been directed.	SA A MA U MD D SD
6	I have a philosophy of life that gives my existence significance.	SA A MA U MD D SD
7	Basically, I am living the kind of life I want to live.	SA A MA U MD D SD
8	I know where my life is going in the future.	SA A MA U MD D SD
9	In thinking of my life, I see a reason for my being here.	SA A MA U MD D SD

10	I have a framework that allows me to understand or make sense of my life.	SA A MA U MD D SD
11	In achieving life's goals, I have felt completely fulfilled.	SA A MA U MD D SD
12	I have a sense that parts of my life fit together into a unified pattern.	SA A MA U MD D SD
13	I have a mission in life that gives me a sense of direction.	SA A MA U MD D SD
14	I have a clear understanding of the ultimate meaning of life.	SA A MA U MD D SD
15	My personal existence is orderly and coherent.	SA A MA U MD D SD
16	My life is running over with exciting good things.	SA A MA U MD D SD

Appendix E: Example of Bereavement Experiences Index (BEI)

Bereavement Experiences Index

NAME: …… DATE**:** ……

The statements below are concerned with your experience of bereavement. They are thoughts and feelings which have been expressed by people who have lost their loved ones through death.

Please indicate how close each of the statements is to your experience by circling the number on the right-hand side which best describes how relevant the statement is to you.

Completely False	Mostly False	Partly False	Partly True	Mostly True	Completely True	Not Applicable
1	2	3	4	5	6	N/A

The 'Not Applicable' should be circled when a statement does not apply to your situation.

1	I often think about times we spent together in the past.	1	2	3	4	5	6	N/A
2	I think about what he would say or do if he was here.	1	2	3	4	5	6	N/A
3	Certain thoughts are very difficult to put out of my mind.	1	2	3	4	5	6	N/A
4	I am able to stop myself from thinking about anything too deeply.	1	2	3	4	5	6	N/A
5	Everything seems completely futile and meaningless without him.	1	2	3	4	5	6	N/A
6	It still seems unreal and unbelievable to me.	1	2	3	4	5	6	N/A
7	When I first heard about his death, I thought 'this cannot be happening to me'.	1	2	3	4	5	6	N/A
8	I often think about how we never had the chance to talk to each other and say goodbye.	1	2	3	4	5	6	N/A
9	It was better for him that he died than to have to suffer any further.	1	2	3	4	5	6	N/A
10	I think about why it had to happen to us.	1	2	3	4	5	6	N/A

Completely False	Mostly False	Partly False	Partly True	Mostly True	Completely True	Not Applicable
1	2	3	4	5	6	N/A

11	I miss him constantly.	1	2	3	4	5	6	N/A
12	It was better for him that he had a quick death rather than a slow and painful one.	1	2	3	4	5	6	N/A
13	It seems so unfair.	1	2	3	4	5	6	N/A
14	I am grateful for the opportunity we had to sort out everything before he died.	1	2	3	4	5	6	N/A
15	I think of him as happy and carefree in another place.	1	2	3	4	5	6	N/A
16	I sometimes ‘see’ him even though he is dead.	1	2	3	4	5	6	N/A
17	I sometimes wonder where he is now.	1	2	3	4	5	6	N/A
18	I feel angry that I have been left alone.	1	2	3	4	5	6	N/A
19	I am making plans for the future.	1	2	3	4	5	6	N/A
20	I feel guilty when I try to put thoughts of him out of my mind.	1	2	3	4	5	6	N/A
21	I think about how he will not be here for future events.	1	2	3	4	5	6	N/A
22	I think about how I did everything that could have been done for him before he died.	1	2	3	4	5	6	N/A
23	I think about how well he coped when he was ill.	1	2	3	4	5	6	N/A
24	I feel guilty that I am not more my usual self with family and friends.	1	2	3	4	5	6	N/A
25	I sometimes ‘hear’ him even though he is dead.	1	2	3	4	5	6	N/A
26	I am easily irritated by others.	1	2	3	4	5	6	N/A

Completely False 1	Mostly False 2	Partly False 3	Partly True 4	Mostly True 5	Completely True 6	Not Applicable N/A

27	I feel anger at God for letting it happen.	1	2	3	4	5	6	N/A
28	I tell myself that I must accept it.	1	2	3	4	5	6	N/A
29	It seems to me that something more could have been done for him.	1	2	3	4	5	6	N/A
30	I have the feeling that I may in some way have contributed to his death.	1	2	3	4	5	6	N/A
31	I think about how much he prepared everything for me so that I would be alright afterwards.	1	2	3	4	5	6	N/A
32	I feel guilty that I was not there at the moment he died.	1	2	3	4	5	6	N/A
33	I worry about financial problems.	1	2	3	4	5	6	N/A
34	I find it very difficult to attend social gatherings.	1	2	3	4	5	6	N/A
35	I have dreams that it was all a mistake and didn't really happen at all.	1	2	3	4	5	6	N/A
36	I have had dreams in which he was living.	1	2	3	4	5	6	N/A
37	My friends seem to have changed towards me.	1	2	3	4	5	6	N/A
38	I sometimes feel his presence even though he is dead.	1	2	3	4	5	6	N/A
39	I miss having someone to be physically close to.	1	2	3	4	5	6	N/A
40	I feel guilty at being able to enjoy myself.	1	2	3	4	5	6	N/A
41	I have the feeling that I am watching myself going through the motions of living.	1	2	3	4	5	6	N/A

Completely False	Mostly False	Partly False	Partly True	Mostly True	Completely True	Not Applicable
1	2	3	4	5	6	N/A

42	I talk to him as though he was here.	1	2	3	4	5	6	N/A
43	I sometimes find myself looking for him in a crowd.	1	2	3	4	5	6	N/A
44	I don't like to talk about it.	1	2	3	4	5	6	N/A
45	My thinking is confused.	1	2	3	4	5	6	N/A

RS: 9. 12. 14. 15. 19. 22. 23. 28. 31

Appendix F: Example of Adapted Version of the Royal Free Interview for Spiritual and Religious Beliefs

We are going to ask you some questions about your religious and spiritual beliefs. **Please try to answer every question even if you have little interest in religion.**

1. Would you say that you have a **religious** or **spiritual** understanding of your life? (Please tick relevant box)

   ☐ Religious ☐ Spiritual ☐ Religious & Spiritual ☐ Neither religious nor spiritual

2. Some people hold strongly to their views and others do not. How strongly do you hold to your religious/spiritual view of life? Circle the number that best describes your view.

   0 1 2 3 4 5 6 7 8 9 10

   None. Weakly held view Strongly held view

3. Do you have a specific religion? (Please tick relevant box)

   ☐ I do not observe a religion.

   ☐ Church of England/Anglican. ☐ Roman Catholic. ☐ Other Christianity.

   ☐ Islam. ☐ Judaism. ☐ Hinduism. ☐ Sikhism. ☐ Buddhism. ☐ Other.

4. Can you give more details (e.g. denomination, sect)……

5. How often do you attend religious services? (Please tick relevant box)

   ☐ Daily. ☐ More than once a week. ☐ At Least Weekly.

   ☐ At Least Monthly. ☐ Less Often. ☐ Rarely or Never.

6. How often do you pray or meditate on your own? (Please tick relevant box)

   ☐ Daily. ☐ More than once a week. ☐ At Least Weekly.

   ☐ At Least Monthly. ☐ Less Often. ☐ Rarely or Never.

7. How important to you is the practice of your beliefs (e.g. prayer, private meditation, religious services) in your day-to-day life? Please circle the number on the scale which best describes your view.

0 1 2 3 4 5 6 7 8 9 10

Not necessary Essential

8. Do you believe in a spiritual power or force other than yourself that can *influence* what happens to you in our day-to-day life? Please circle the number on the scale which best describes your view.

0 1 2 3 4 5 6 7 8 9 10

No influence Strong influence

9. Do you believe in a spiritual power or force other than yourself that enables you to *cope* personally with events in your life? Please circle the number on the scale which best describes your view.

0 1 2 3 4 5 6 7 8 9 10

No help A great help

10. Do you believe in a spiritual power or force other than yourself that influences world affairs, e.g. wars? Please circle the number on the scale which best describes your view.

0 1 2 3 4 5 6 7 8 9 10

No influence Strong influence

11. Do you believe in a spiritual power or force other than yourself that influences natural disasters, like earthquakes, floods? Please circle the number on the scale which best describes your view.

0 1 2 3 4 5 6 7 8 9 10

No influence Strong influence

Appendix G: Example of Study 1 Semi-Structured Interview Schedule

A Follow-Up Study of Personal Beliefs and Spousal Bereavement

Semi-Structured Interview Schedule

1. Introductory conversation, followed by: Can you tell me a little about your life now and during the intervening years since we last spoke to you?

    (a) Since we last spoke to you can you tell me about any *experiences* you have had that have been important to you?

    (b) Can you tell me about any experiences you have found particularly difficult?

2. Can you tell me whether you have any religious or spiritual *personal beliefs*? If you do not have religious or spiritual beliefs can you tell me about your philosophy of life beliefs?

    (a) How strong would you say your personal beliefs are?

    (b) Can you give me some details about the content and practice of your personal beliefs? (For example, church attendance, reading sacred texts, meditation, prayer).

    (c) In what ways do you use prayer? Do you ever use prayer to help with worrying thoughts?

    (d) Can you tell me what aspects of your personal beliefs are most important to you and why?

    (e) Do you ever actively seek out information relevant to your personal beliefs? (For example, watching religious television programs, reading religious texts other than the bible, searching religion on the internet). (*Curious, inquisitive*).

3. During the intervening years can you tell me the role played by your personal beliefs in helping you develop a sense of *acceptance* toward your bereavement?

    (a) How important would you say your personal beliefs have been in the bereavement process during the intervening years?

4. Can you tell me in what ways your personal beliefs have helped you to *cope* with your bereavement in the intervening years? *(Cope = deal with, manage effectively)*.

    (a) Can you think of a particular occasion when your personal beliefs were useful in helping you to cope?

5. Can you tell me in what ways your personal beliefs have helped you to *adjust* to your bereavement in the intervening years? *(Adjust = change, adapt lifestyle)*.

    (a) Can you think of a particular occasion when your personal beliefs were useful in helping you to adjust?

6. Do you think your personal beliefs have changed during the intervening years since your bereavement, and if so in what ways?

7. Do you think your feelings (*emotions*) have changed since the experience of your bereavement, and if so in what ways?

    (a) Do you think your personal beliefs have influenced your ability in managing (or controlling) your feelings since your bereavement, and if so in what ways?

    (b) Can you tell me whether your personal beliefs have helped you deal with emotional times of year (e.g. anniversaries, birthdays, Christmas)?

8. Do you think the experience of your bereavement has made you think more about *(existential questions)* religion/spirituality and the meaning and purpose of life?

9. As you have matured as a person, would you say that you think about questions related to religion, spirituality, and the meaning and purpose of life more so now than when you were younger, and if so in what ways?

Thank you

Main Areas of Investigation

Experiences of coping & adjustment, personal beliefs, acceptance, coping, adjustment, emotion, existential questioning.

Appendix H: Reflexivity Study 1 – Researcher Reflections, Observations, and Comments Related to Conducting Study 1

Reflexivity refers to a component within qualitative research whereby the researcher outlines likely factors that may have shaped or influenced aspects of the research process. Such factors often include the influence of the researcher's own beliefs, interests, experiences, and personal history; the influence of researcher interactions or relationships with participants; and can include how carrying out the research may have affected the researcher in some way and about what lessons may have been learnt from the experience (Willig, 2001; Yardley, 2000). As such, the reflexivity section attempts to acknowledge the subjective, unique, and inseparable role of the researcher in all aspects of the research process. Although reflexivity sections are not always included within qualitative research they are encouraged in part because they can help the reader further appreciate and evaluate the research conducted and findings identified. (See also Appendix M, Study 2 Reflexivity section, for more reflexivity observations).

As this was only the second time I had carried out a qualitative study I felt it important to learn as much as possible about the epistemological and philosophical foundations underlying qualitative research. In the process of my reading I learnt that several researchers (e.g. Brocki & Wearden, 2006; Lincoln & Guba, 1985; Yardley, 2000) had discussed how qualitative research could not simply be evaluated by the same criteria used to judge quantitative research. With this in mind, I endeavoured to follow the guidelines for conducting valid qualitative research outlined by several experts in this field (e.g. Elliot, Fischer, & Rennie, 1999; Malterud, 2001; Parker, 2004; Smith, 2003; Yardley, 2000), and also provided by the British Psychological Society (BPS, 2007). In particular, I aspired to the principles proposed by Yardley (2000) and discussed in Smith (2003) in terms of being: sensitive to the context of the background literature, to the methods of analysis used, to the circumstances of the participants, and to participant data; in the commitment to in-depth engagement in all aspects of the research process and in working with the data; in the rigour of the completeness, dedication, and level of intensity used in prolonged data collection and time intensive analysis; and in the transparency and cogency in disclosing details of the methods and analyses used (Smith, 2003; Yardley, 2000). Finally, with regard to the criteria of impact and importance of the research, in both Study 1 and 2 I aimed to identify findings that would be theoretically new and insightful but also potentially useful for clinicians, researchers, and lay people to know. It is hoped that the qualitative findings have both wider relevance in the psychology of religion in detailing how religion functions or is used by certain people in specific contexts, and may also have relevant transferability to the specific population analysed, namely British older adults who have lost a spouse and who attribute varying levels of importance to Christian religious belief and practice.

As a student of psychological research, and therefore still a novice qualitative researcher, for the first qualitative study of my PhD it was perhaps helpful that I was able to interview a sample who had been interviewed in a previous study. This was useful because these older adult participants would be familiar with the format of an interview and would require little overt instruction or encouragement in order to speak openly and at length. In addition, during preparation and recruitment I was able to read participant original transcripts to familiarise myself with participants, and to discuss the follow-up study and prepare a recruitment letter with members of the original research team. Thus, I was able to be presented to participants as a student who was working on an individual follow-up study but still associated with the original researchers/interviewers who participants had come to know and trust. As such, I could be presented as somebody who was trustworthy and empathetic toward participant circumstances and perspectives, characteristics that may be important from the

perspective of bereaved older adults. These features contributed toward maximising recruitment potential and in gathering valuable follow-up data.

Perhaps one of the biggest decisions for my first qualitative study involved how to approach the analysis and present the research findings. These processes were influenced by several sources, for example: by providing summaries of how participants had coped and adjusted since last interviewed to members of the original research team; by presenting an earlier version of the findings at national and international conferences and receiving feedback; and by discussing and justifying themes with my supervisor. Engagement in these activities gave me the confidence to analyse the data at both the level of the overall sample and by grouping participants into strength of belief sub-groups. This approach was opportunistic and advantageous for a first study as it allowed me to explore differences and similarities in coping influenced by differences in personal beliefs. This approach also gave me the direction for Study 2.

Appendix I: Example of Study 2 Informed Consent Form

Personal Beliefs, Meaning Making and the Experience of Bereavement

Consent Form for Research Participants

Information sheet

I am John Spreadbury a postgraduate research student in the health psychology research group at the University of Southampton. I am requesting your participation in a study regarding the role of personal beliefs in the bereavement process. This will involve an interview where I would like you to tell me about your experience of bereavement from your spouse and the importance of your personal beliefs in your life. I have some fairly general questions about your personal beliefs be they religious, spiritual, or philosophy of life, how you coped with your bereavement, and whether you feel your personal beliefs helped you make sense of your bereavement. The interview will probably take about one hour to one hour and a half of your time and will be tape recorded for later transcription. Personal information will not be released to or viewed by anyone other than researchers involved in this project and all tapes will be destroyed immediately after transcription. Results of this study will not include your name or any other identifying characteristics.

Your participation is voluntary and you may withdraw your participation at any time.
If you have any questions please ask them now, or contact me, John Spreadbury at the University of Southampton by telephone on (*details omitted*) or by email on Jhs101@soton.ac.uk. Or by contacting Professor Peter Coleman by telephone on (*details omitted*) or by email on P.G.Coleman@soton.ac.uk.

Signature Date
Name John Henry Spreadbury

Statement of Consent

I _____ have read the above informed consent form.
[participants name]

I understand that I may withdraw my consent and discontinue participation at any time without penalty or loss of benefit to myself. I understand that data collected as part of this research project will be treated confidentially, and that published results of this research project will maintain my confidentiality. In signing this consent letter, I am not waiving my legal claims, rights, or remedies. A copy of this consent letter will be offered to me.

(Circle Yes or No)

I give consent to participate in the above study.	Yes	No
I give consent to be audio taped.	Yes	No
I understand that these audio tapes will be destroyed after analysis	Yes	No

Signature Date
Name *[participants name]*

I understand that if I have questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I can contact the Chair of the Ethics Committee, School of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 3995.

Appendix J: Example of Study 2 Debriefing Form

Personal Beliefs, Meaning Making and the Experience of Bereavement

Debriefing Statement

The aim of this research was to investigate the influence of important personal beliefs, in this case religious beliefs, on meaning making and coping with bereavement from a spouse in later life. We hope to examine the role of personal beliefs following bereavement and identify how personal beliefs translate into modes of making sense of loss and coping with grief. It is expected that participant personal beliefs will provide subjective reassurance and comfort, existential understanding, and a continued bond to the lost spouse. Your data will help our understanding of how the personal beliefs of older adults are used in coping with bereavement in the years following the loss of a spouse.

Once again results of this study will not include your name or any other identifying characteristics. The research did not use deception. You may have a copy of this summary if you wish. You may also have a summary of the research findings once this project is completed.

If you have any further questions please contact me, John Spreadbury, at the University of Southampton, School of Psychology, by telephone on (*details omitted*) or by email on Jhs101@soton.ac.uk. Or by contacting Professor Peter Coleman by telephone on (*details omitted*) or by email on P.G.Coleman@soton.ac.uk.

Thank you for your participation in this research.

Signature _____ Date _____

Name

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 3995.

Appendix K: Example of Study 2 Socio-Demographic Questionnaire

Participant Code:…… Age:…… Gender:……

(*Health Status*)

1. How is your general physical health?.....
……
……

(*Mental Health*)

2. How is your general mental health?.....
……
……

(*Health Behaviours*)

3. Do you drink alcohol or smoke?.....
……
……

(*Education*)

4. Could you briefly tell me your level of education? (E.g. School, College, University)….
……
……

(*Employment Status*)

5. Can you tell me your present employment status? (E.g. Employed, unemployed, retired).
……
……

(*Income*)

6. Could you broadly describe your socioeconomic status?.....
……
……

(*Geographic Region*)

7. Where do you live?.....
……
……

(*Marital Status*)

8. What is your present marital status?.....
……
……

(*Social Support*)

9. Do you have any children?.....
……
……

(*Race/ethnicity*)

10. What is your race/ethnicity?.....
……
……

Appendix L: Example of Beliefs and Values Scale

This questionnaire concerns your beliefs and views about life. Please circle the ONE response that best describes your view for each of the statements.

1. I am a spiritual person	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
2. I believe I have a spirit or soul that can survive my death	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
3. I believe in a personal God	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
4. I believe meditation has value	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
5. I believe God is an all pervading presence	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
6. I believe what happens after I die is determined by how I have lived my life	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
7. I believe there are forces for evil in the Universe	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
8. Although I cannot always understand, I believe everything happens for a reason	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
9. I believe human physical contact can be a spiritual experience	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
10. I feel most at one with the world when surrounded by nature	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
11. I believe in life after death	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
12. I am a religious person	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
13. Religious ceremonies are important to me	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
14. I believe life is planned out for me	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
15. I believe God is a life force	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
16. At least once in my life, I have had an intense spiritual experience	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
17. I believe that there is a heaven	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
18. I believe the human spirit is immortal	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
19. I believe prayer has value	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
20. I believe there is a God	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**

Appendix M: Reflexivity Study 2 – Researcher Reflections, Observations, and Comments Related to Conducting Study 2

In contrast to Study 1 (see Appendix H, Study 1 reflexivity section, for an introduction into the concept of reflexivity), the bereaved older adults in Study 2 had not discussed their bereavement experiences in a research study before. As such, in interacting and discussing with participants subjects often considered personal such as one's bereavement and religious beliefs, sensitive and thoughtful interpersonal and communication skills were needed. In this respect the guidance I received from a counsellor experienced in practice and research with bereaved older adults was invaluable in helping me collect rich and useful data. Indeed, the interpersonal skills and participant awareness needed by researchers during interviews with bereaved participants have been likened to the interpersonal skills used by counsellors when working with clients. (As an aside many of the below observations, including those on interacting with participants, equally apply to Study 1).

Research with bereaved participants is perhaps unlike research with other participant groups traditionally used in much psychological research because research with the bereaved can be emotionally demanding and potentially upsetting for both the participant and researcher. During interviews, in telling their story, the bereaved are allowing the interviewer to enter into one of the most traumatic and distressing aspects of their personal world. As such, in order to collect rich and useful data it was essential to be sensitive and empathetic toward each participant's unique circumstances and to make participants feel as comfortable and secure as possible when describing their experiences. Encouraging participants in disclosing their thoughts and feelings was achieved by being friendly, accessible, receptive and attentive toward participants during all interactions, be they before the interview when arranging times to meet, during the interview itself, and following interviews. Being conscientious toward the well-being of participants during all interactions contributed toward building and maintaining a relationship of trust so that participants could feel confident in providing information about any aspect of their experience.

During the interview itself it was also important to present oneself as a good listener, as empathetic, and as non-judgemental in order to encourage and engage participants in talking openly and candidly. In both Study 1 and 2, prior to interviews a small number of participants articulated feeling slightly nervous about participating in the study. It was therefore important to listen carefully to participant concerns and to reassure and explain to participants about the nature of the study and to highlight that it was of interest to record the participant's own account of coping and that all information would remain anonymous and confidential. Once participants were made to feel comfortable they soon became enthusiastic about talking, to the extent that many were happy to talk for longer than was initially agreed. Indeed, once interviews were completed a number of participants mentioned how enjoyable it had been talking to somebody interested in their experience, with some also commenting that it had been helpful to talk to somebody objective who was willing to listen. Maintaining a friendly, attentive, and receptive disposition and being sensitive and empathetic toward participants throughout interviews was immensely helpful in collecting rich data. Furthermore, these interpersonal practices allowed me to remain in contact with several participants who provided me with additional information following the interview and who I could return to for clarification on anything that was discussed during interviews.

In addition to the importance of interpersonal skills in increasing access to rich data, the location of interviews was also important during data collection. Each interview was conducted in the participant's own home and this environment further contributed toward participants feeling comfortable in talking about their religious belief and practice, and their bereavement. Furthermore, many of the participants' homes contained religious icons, pictures, and imagery

that not only served to reinforce the importance of religion in the lives of participants, but could also be brought into the interview discussion. For example, many participants were able to illustrate their thoughts and feelings using religious pictures and especially through literary sources such as poetry books, books on religion, and passages from the Bible that participants had close at hand and could refer to. On many occasions participants were able to read aloud from religious books (e.g. the Bible) and explain how certain passages were helpful in coping in a natural and spontaneous way that would have been prevented or restricted if interviews had been conducted in an alternative environment (e.g. in a laboratory).

Although in discussing subjects such as religious beliefs, death, and coping there was the potential for self-presentation biases on the part of the participant, whereby participants may have articulated overly positive or optimistic accounts of religion or coping, in practice participants discussed quite openly their coping failures as much as their successes; their religious uncertainties and doubts; and their disapproval or frustration with religious figures, institutions, or practices. Furthermore, participants displayed a range of emotions during interviews from sadness and crying to happiness and laughter. This openness left me feeling confident that self-presentation biases had little confounding influence on the content of religious belief and practice articulated as helpful (and unhelpful) in coping. An additional concern that participants may possibly be motivated to use the interview for some kind of therapeutic benefit also appeared unfounded with some participants articulating that they had been offered but declined bereavement counselling from their GP.

A further important process during data collection and analysis was that I attended regular church services similar to the services attended by participants. Regular church attendance was helpful to the research by allowing me to gain a deeper appreciation of the meaning and significance related to different religious practices and rituals, and helped me to learn more about the intricacies of religious cognition and how certain beliefs are relevant to coping with a significant bereavement. Importantly, as analysis was a lengthy and labour intensive process that developed over several months, regular church attendance enriched the analytic process by allowing me to take an insider's perspective on the role of religious belief and practice in day-to-day behaviour, thinking, decision making, and coping.

With regard to the creation, development, and presentation of themes and interpretations, a number of different activities influenced my ongoing thinking. For example, presenting and discussing my findings with my supervisor helped me to verbally express and justify my interpretations and themes, while hearing my interpretations repeated back to me helped me to question and challenge my own thinking. Another useful activity was engaging in formal presentations of my research to different academic audiences as it allowed me to evaluate the reactions of those from a range of backgrounds and receive useful and unexpected feedback. Indeed, both formal presentations and personal discussions about my research with people from different academic and social backgrounds highlighted the varying understandings and attitudes towards emotive topics such as religion, science, death, and loss. These activities encouraged me to be mindful of the different impact my interpretations would have for different audiences. Also, being able to draw on my fieldnotes and a personal diary of my evolving thoughts reminded me of the details of my early thinking. Engagement in all of these activities contributed toward helping me shape my developing interpretations and produce an account of the role of religion in bereavement that was comprehensive yet accessible.

With regard specifically to bereavement research and related to the practice of immersing oneself in the data, a practice recommended by most qualitative researchers, a word of caution is recommended for researchers new to qualitative research based on my own experience. Prolonged data immersion and analysis lasting many months and involving repeated reading or listening to participant accounts of bereavement which may include distressing or upsetting details may potentially have a negative or harmful effect on the

emotional well-being of a sensitive researcher. Indeed, I found that repeated studying of participant accounts of bereavement and suffering had the effect of leaving me emotionally drained and tired, and gradually negatively affecting my mood. Furthermore, I found it difficult to mentally switch off from thinking about participant accounts while the details of accounts of bereavement or suffering would often intrude into my thinking and were sometimes experienced as distressing, disturbing, or anxiety-provoking. Although immersion in participant data is a necessary practice, when the material being analysed is of a highly emotional or distressing nature it is important for the researcher to recognise when the material is affecting oneself emotionally in a negative or harmful way and to have some safeguards in place. This may be especially important if the researcher themselves have experienced a significant bereavement.

Finally, related to a criteria for conducting valid qualitative research known as *commitment and rigour* discussed by Yardley (2000), it is worth mentioning that certainly by the end of conducting two qualitative studies I had increased my competence and skill in using qualitative research methods. Indeed, by the end of my qualitative research I felt in a better position to recognise the limitations of my own research, better equipped to review and evaluate the qualitative research of others, and more confident to approach qualitative research in the future. Indeed, these qualities gained may contribute toward enhancing the validity of work on future qualitative research. In addition, having carried out two qualitative studies I appreciate more deeply that the final product of the qualitative research presented is the result of several subjective factors. For example, as a result of a personal interpretation and understanding of the theoretical literature; as the sum experience of meeting, interviewing, and getting to know participants over the course of two separate studies; and as part of the process of moving from novice to aspirant qualitative researcher during a particular socio-cultural and personal maturational period. In sum, the final product of the research is perhaps inseparable from the thoughts, feelings, and experiences of the researcher during the course of the research.

Appendix N: Example of Study 2 Semi-Structured Interview Schedule

Semi-Structured Interview Schedule

1. For the purposes of the tape, could you please state your age, (previous) occupation, and tell me a little bit about yourself (e.g. background, children, interests, hobbies)?

2. Can you tell me whether you have any religious or spiritual personal beliefs?

    (a) How long have you held your (religious) belief? (Did you attend Sunday school?)

    (b) Can you give me some details about the content and practice of your (religious) belief? (e.g. denomination, reading sacred texts, Eucharist/Communion).

    (c) How often do you attend church?

    (d) What does church attendance mean to you?

    (e) If you pray, what does prayer mean to you?

3. Can you tell me in what ways your (religious) belief gives you meaning/purpose in life/is important?

4. I would like to ask you about your bereavement now if that is alright. Can you tell me about the circumstances of your bereavement?

    (a) How long ago did the bereavement happen?

    (b) How long were you married for?

    (c) Did your husband/wife share the same religious belief as you?

5. Can you tell me how you have coped/are coping?

6. Can you tell me what role your (religious) belief has played/is playing in the coping process?

7. Can you tell me more specifically what parts of your (religious) belief or practice have helped you cope? (e.g. stories/themes/content from the Bible, belief in an afterlife, belief in a benevolent/protective God, Eucharist/Communion, prayer).

8. According to your (religious) belief can you tell me what happens when somebody dies?

    (a) Can you tell me what parts of your (religious) belief concerning death were most important to you in coping with your bereavement?

    (b) Can you tell me what you think your husband/wife's afterlife fate is/has been? (Can you tell me what you think has happened to your partner? How long do you think one spends in purgatory/judgement/hell?)

9. (How much sense would you say you have made of your loss?) *Sense making*.

    (a) Do you think your (religious) belief has been influential in helping you make sense of your loss?

    (b) What parts of your belief/practice were important in helping you make sense of your loss?

10. (Despite the loss, have you been able to find any benefit from your experience of the loss?) *Benefit finding*.

    (a) Has your (religious) belief helped you to find any benefit from your experience of the loss?

    (b) What parts of your belief/practice were important in benefit finding?

11. (Do you feel that you are different, or that your sense of identity has changed, as a result of your loss?) *Identity change*.

    (a) If so, do you think your (religious) belief or practice has influenced a change in your identity or sense of self?

12. Has the experience of your bereavement made you question your (religious) belief or aspects of your (religious) belief (e.g. concepts of purgatory/hell/judgement), and if so in what ways?

    (a) Have your beliefs changed in any way since your bereavement? (e.g. become stronger or weaker).

13. Do you feel a connection/bond/continued relationship with your husband/wife?

    (a) If so, can you tell me whether your (religious) belief or practice has played a role in the connection or bond you feel?

    (b) Can you describe your connection or bond for me?

14. Can you tell me whether your (religious) belief gives you a sense of hope or optimism for the future, and if so in what ways?

15. Finally, if a colleague (or friend) in your congregation (or someone who shares the same belief as you) suffered a significant bereavement can you tell me what you would say to them if they came to you and asked how you coped?

    (a) Are there any parts of your (religious) belief or practice that you would specifically highlight as beneficial, or talk to them about?

Thank you, followed by debriefing statement.

Appendix O: Example of Study 3 Information/Consent Form

A Questionnaire Survey Exploring Quality of Life, Life Satisfaction, Religious Belief and Practice, and General Health in British Older Adults

Statement of Consent

I am John Spreadbury a PhD research student in the health research group in the School of Psychology at the University of Southampton. I am requesting your participation in a study investigating the factors that increase and reduce life satisfaction and quality of life in British older adults. This will involve the completion of a questionnaire asking you about any important religious beliefs or practices you may have, your perception of your general physical and mental health, how satisfied with your life circumstances you feel, your perception of your quality of life, and a small number of background variables (e.g. age, gender). Completion of the questionnaire should take no longer than approximately 30 to 45 minutes. Personal information will not be released to or viewed by anyone other than researchers involved in this project. Results of this study will not include your name or any other identifying characteristics.

Completion and return of this questionnaire will be taken as evidence of you giving informed consent to be included as a participant in this study, for your data to be used for the purposes of research, and that you understand that published results of this research project will maintain your confidentiality. Your participation is voluntary and you may withdraw your participation at any time. A summary of this research project will be supplied to you upon request.

If you have any questions and/or would like to request a project summary please contact me, John Spreadbury, at the School of Psychology, University of Southampton, Southampton, SO17 1BJ, or by telephone on (*details omitted*) or by email on Jhs101@soton.ac.uk.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 5578.

Appendix P: Example of Study 3 Debriefing Form

A Questionnaire Survey Exploring Quality of Life, Life Satisfaction, Religious Belief and Practice, and General Health in British Older Adults

Debriefing Statement

The aim of this research was to investigate whether there are any significant differences in important areas of quality of life among British older adults as a result of differences in older age group (e.g. 55-64, 65-74, 75-84, and 85 years and over); and to examine what factors increase and reduce quality of life and life satisfaction in these age groups. A related aim was to investigate whether religious belief and practice can predict or contribute toward an understanding of quality of life and increased health in later life. It is expected that for some British older adults religious belief and practice will contribute toward increased quality of life, while for others this may not be the case. Your data will help our understanding about the range of psychological and social factors that are important in later life and that may be related to increased physical and mental health and quality of life. Once again results of this study will not include your name or any other identifying characteristics. The research did not use deception. You may have a copy of this summary if you wish. You may also have a summary of the research findings once this project is completed.

If you have any further questions please contact me John Spreadbury by telephone on (*details omitted*) or by email on Jhs101@soton.ac.uk. Or by contacting Professor Peter Coleman by telephone on (*details omitted*) or by email on P.G.Coleman@soton.ac.uk.

If you have experienced a recent bereavement and would like further information or support about bereavement and coping with grief you can visit the Cruse Bereavement Care website on www.crusebereavementcare.org.uk or alternatively you can call the Cruse Bereavement Care helpline on 0844 477 9400. Cruse Bereavement Care is a nationally recognised organisation aimed at providing education, support, and advice on all issues related to bereavement.

Thank you for your participation in this research.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 5578.

Appendix Q: Example of Study 3 Socio-Demographic Questionnaire

The following items are some general background questions.

1	What is your gender? (please circle)	Male	Female

2	What is your age? (please write in the box)	……..Years

3	How would you describe your race/ethnicity? (please circle)	White	Indian	Pakistani	Bangladeshi	Black Caribbean
		Black African	Black other	Chinese/South East Asian	Other, please state: ……	

4	Are you at present married? (please circle)	Yes	No

5	What is your highest level of education? (please circle)	School	College	University	Postgraduate

6	What is your present employment status? (please circle)	Employed full time	Employed part time	Unemployed	Retired

7	In general, would you say your present financial situation is: (please circle)	Excellent	Very Good	Good	Fair	Poor

8	Have you ever experienced bereavement from a spouse or partner? (please circle)	Yes	No

If "Yes", please answer questions 9, 10, 11, and 12 below. If "No" please go to Section 2.

9	How long ago did your spouse or partner pass away? (please write in box)	

10	How long were you married to your spouse or partner who passed away? (please write in box)	

11	How much forewarning did you have that your spouse was going to pass away? (please write in box)	…...Hours……Days…..Weeks…..Months…..Years

12	What was your spouse or partner's cause of death? (please write in box)	

Appendix R: Example of Maranell's (1974) Ritualism Subscale

Please indicate the extent to which you agree or disagree with each statement. Please circle one number for each statement.

		Strongly disagree	**Somewhat disagree**	**Undecided**	**Somewhat agree**	**Strongly agree**
1	The ritual of worship is a very important part of religion.	0	1	2	3	4
2	One of the most important aspects of religion is the religious service itself.	0	1	2	3	4
3	The precision and orderliness with which religious ceremonies are performed is important to me.	0	1	2	3	4
4	The more a religious service is ritualized the more it has meaning for me.	0	1	2	3	4
5	Religion is most real to me during my attendance at public church or religious services.	0	1	2	3	4
6	I think that the placement and treatment of the various articles of worship is very important in a worship service.	0	1	2	3	4
7	When I recall my experiences with religion I most readily remember the impressive formal rites and rituals.	0	1	2	3	4
8	I like to think that people all over are going through nearly the same ritual in their religious worship.	0	1	2	3	4
9	A religious service must be beautiful to be really meaningful to me.	0	1	2	3	4
10	It is important to me that a religious service be standardized.	0	1	2	3	4
11	I do not think that the sequence of prayers, songs, etc., is very important in religious services.	0	1	2	3	4
12	Prayers in religious services are better if they are formalized – as litanies, that is, with responses.	0	1	2	3	4

Appendix S: Subscales from the Brief Multidimensional Measure of Religiousness/Spirituality

Public Religious Practice

For each item, please circle the relevant response.

		More than once a week	Every week or more often	Once or twice a month	Every month or so	Once or twice a year	Never
1	How often do you go to religious services?	1	2	3	4	5	6
2	Besides religious services, how often do you take part in other activities at a place of worship?	1	2	3	4	5	6

Private Religious Practice

For each item, please circle the relevant response.

		More than once a day	Once a day	A few times a week	Once a week	A few times a month	Once a month	Less than once a month	Never
1	How often do you pray privately in places other than at church?	1	2	3	4	5	6	7	8
2	Within your religious or spiritual tradition, how often do you meditate?	1	2	3	4	5	6	7	8
3	How often do you watch or listen to religious programs on TV or radio?	1	2	3	4	5	6	7	8
4	How often do you read the Bible or other religious literature?	1	2	3	4	5	6	7	8

		At all meals	Once a day	At least once a week	Only on special occasions	Never
5	How often are prayers or grace said before or after meals in your home?	1	2	3	4	5

Religious and Spiritual Coping

Think about how you try to understand and deal with major problems in your life. To what extent is each of the following involved in the way you cope? For each item, please circle one number that best represents your view.

		A great deal	Quite a bit	Somewhat	Not at all
1	I think about how my life is part of a larger spiritual force.	1	2	3	4
2	I work together with God as partners.	1	2	3	4
3	I look to God for strength, support, and guidance.	1	2	3	4
4	I feel that God is punishing me for my sins or lack of spirituality.	1	2	3	4
5	I wonder whether God has abandoned me.	1	2	3	4
6	I try to make sense of the situation and decide what to do without relying on God.	1	2	3	4

		Very involved	Somewhat involved	Not very involved	Not involved at all
7	To what extent is your religion involved in understanding or dealing with stressful situations in any way?	1	2	3	4

Religious Forgiveness

Because of my religious or spiritual beliefs:

		Always or almost always	Often	Seldom	Never
1	I have forgiven myself for things that I have done wrong.	1	2	3	4
2	I have forgiven those who hurt me.	1	2	3	4
3	I know that God forgives me.	1	2	3	4

Religious/Spiritual Experience (Daily Spiritual Experience)

The following items deal with possible religious/spiritual experiences that people sometimes have. To what extent can you say you experience the following? **For each item please circle one number.**

		Many times a day	Every day	Most days	Some days	Once in a while	Never or almost never
1	I feel God's presence.	1	2	3	4	5	6
2	I find strength and comfort in my religion.	1	2	3	4	5	6
3	I feel deep inner peace or harmony.	1	2	3	4	5	6
4	I desire to be closer to or in union with God.	1	2	3	4	5	6
5	I feel God's love for me, directly or through others.	1	2	3	4	5	6
6	I am spiritually touched by the beauty of creation.	1	2	3	4	5	6

Religious Support

These questions are designed to find out how much help the people in your congregation would provide if you need it in the future. **For each item please circle one number.**

		A great deal	Some	A little	None
1	If you were ill, how much would the people in your congregation help you out?	1	2	3	4
2	If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?	1	2	3	4

		Very often	Fairly Often	Once in a while	Never
3	How often do the people in your congregation make too many demands on you?	1	2	3	4
4	How often are the people in your congregation critical of you and the things you do?	1	2	3	4

Appendix T: Example of Short-Form 36-Item (SF-36) Health Survey

1. In general, would you say your health is:
   - □ Excellent
   - □ Very Good
   - □ Good
   - □ Fair
   - □ Poor

2. **Compared to one year ago**, how would you rate your health in general **now**?
   - □ Much better now than one year ago
   - □ Somewhat better now than one year ago
   - □ About the same as one year ago
   - □ Somewhat worse now than one year ago
   - □ Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much? (Please circle one number for each item)

		Yes, limited a lot	**Yes, limited a little**	**No, not limited at all**
a	**Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
b	**Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	1	2	3
c	Lifting or carrying groceries.	1	2	3
d	Climbing **several** flights of stairs.	1	2	3
e	Climbing **one** flight of stairs.	1	2	3
f	Bending, kneeling, or stooping.	1	2	3
g	Walking **more than a mile**.	1	2	3
h	Walking **half a mile**.	1	2	3
i	Walking **one hundred yards.**	1	2	3
j	Bathing or dressing yourself.	1	2	3

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? (Please circle one number for each item)

		YES	NO
a	Cut down the **amount of time** you spent on work or other activities.	1	2
b	**Accomplished less** than you would like.	1	2
c	Were limited in the **kind** of work or other activities.	1	2
d	Had **difficulty** performing the work or other activities (for example, it took extra effort).	1	2

5. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (Please circle one number for each item)

		YES	NO
a	Cut down the **amount of time** you spent on work or other activities.	1	2
b	**Accomplished less** than you would like.	1	2
c	Didn't do work or other activities as **carefully** as usual.	1	2

6. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?
   - □ Not at all
   - □ Slightly
   - □ Moderately
   - □ Quite a bit
   - □ Extremely

7. How much **bodily** pain have you had during the **past 4 weeks**?
   - □ None
   - □ Very mild
   - □ Mild
   - □ Moderate
   - □ Severe
   - □ Very severe

8. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework?)
   - □ Not at all
   - □ A little bit
   - □ Moderately
   - □ Quite a bit
   - □ Extremely

9. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks:**

		All of the time	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
a	Did you feel full of life?	1	2	3	4	5	6
b	Have you been a very nervous person?	1	2	3	4	5	6
c	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d	Have you felt calm and peaceful?	1	2	3	4	5	6
e	Did you have a lot of energy?	1	2	3	4	5	6
f	Have you felt downhearted and low?	1	2	3	4	5	6
g	Did you feel worn out?	1	2	3	4	5	6
h	Have you been a happy person?	1	2	3	4	5	6
i	Did you feel tired?	1	2	3	4	5	6

10. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?
    - □ All of the time
    - □ Most of the time
    - □ Some of the time
    - □ A little of the time
    - □ None of the time

11. How TRUE or FALSE is **each** of the following statements for you? (Please circle one number for each item)

		Definitely True	**Mostly True**	**Don't know**	**Mostly False**	**Definitely False**
a	I seem to get ill a little easier than other people	1	2	3	4	5
b	I am as healthy as anybody I know	1	2	3	4	5
c	I expect my health to get worse	1	2	3	4	5
d	My health is excellent	1	2	3	4	5

Appendix U: Example of EUROHIS-Quality of Life 8-Item Index

The following questions ask how you feel about your quality of life, health, or other areas of your life. **Please answer all of the questions.** If you are unsure about which response to give to a question, **please choose the one** that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks.**

		Very poor	**Poor**	**Neither poor nor good**	**Good**	**Very Good**
1	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	**Dissatisfied**	**Neither satisfied nor dissatisfied**	**Satisfied**	**Very satisfied**
2	How satisfied are you with your health?	1	2	3	4	5

		Not at all	**A little**	**Moderately**	**Mostly**	**Completely**
3	Do you have enough energy for everyday life?	1	2	3	4	5

		Very dissatisfied	**Dissatisfied**	**Neither satisfied nor dissatisfied**	**Satisfied**	**Very satisfied**
4	How satisfied are you with your ability to perform your daily activities?	1	2	3	4	5

		Very dissatisfied	**Dissatisfied**	**Neither satisfied nor dissatisfied**	**Satisfied**	**Very satisfied**
5	How satisfied are you with yourself?	1	2	3	4	5

		Very dissatisfied	**Dissatisfied**	**Neither satisfied nor dissatisfied**	**Satisfied**	**Very satisfied**
6	How satisfied are you with your personal relationships?	1	2	3	4	5

		Not at all	A little	Moderately	Mostly	Completely
7	Have you enough money to meet your needs?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
8	How satisfied are you with the conditions of your living place?	1	2	3	4	5

Appendix V: Example of Satisfaction With Life Scale (SWLS)

Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding. The 7-point scale is:

SCALE:

1 = Strongly disagree
2 = Disagree
3 = Slightly disagree
4 = Neither agree nor disagree
5 = Slightly agree
6 = Agree
7 = Strongly agree

_____1. In most ways my life is close to my ideal.

_____2. The conditions of my life are excellent.

_____3. I am satisfied with my life.

_____4. So far I have gotten the important things I want in life.

_____5. If I could live my life over, I would change almost nothing.

Appendix W: Example of Balanced Inventory of Desirable Responding (BIDR)

Using the scale below as a guide, please write a number beside each statement to indicate how true it is.

1	2	3	4	5	6	7
not true			somewhat			very true

____ 1. My first impressions of people usually turn out to be right.

____ 2. It would be hard for me to break any of my bad habits.

____ 3. I don't care to know what other people really think of me.

____ 4. I have not always been honest with myself.

____ 5. I always know why I like things.

____ 6. When my emotions are aroused, it biases my thinking.

____ 7. Once I've made up my mind, other people can seldom change my opinion.

____ 8. I'm just an average person.

____ 9. I am fully in control of my own fate.

____ 10. It's hard for me to shut off a disturbing thought.

____ 11. I never regret my decisions.

____ 12. I sometimes lose out on things because I can't make up my mind soon enough.

____ 13. The reason I vote is because my vote can make a difference.

____ 14. My parents were not always fair when they punished me.

____ 15. I am a completely rational person.

____ 16. I rarely appreciate criticism.

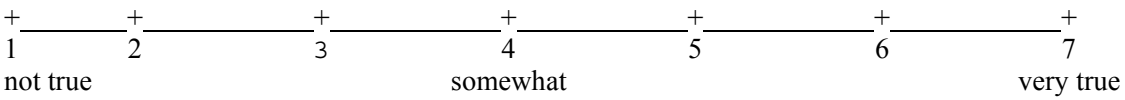
____ 17. I am very confident of my judgments.

____ 18. I have sometimes doubted my ability in making close relationships.

____ 19. It's all right with me if some people happen to dislike me.

____ 20. I don't always know the reasons why I do the things I do.

Using the scale below as a guide, please write a number beside each statement to indicate how true it is.



____ 21. I sometimes tell lies if I have to.

____ 22. I never cover up my mistakes.

____ 23. There have been occasions when I have taken advantage of someone.

____ 24. I never swear.

____ 25. I sometimes try to get even rather than forgive and forget.

____ 26. I always obey laws, even if I'm unlikely to get caught.

____ 27. I have said something bad about a friend behind his/her back.

____ 28. When I hear people talking privately, I avoid listening.

____ 29. I have received too much change from a salesperson without telling him or her.

____ 30. I always declare everything at customs.

____ 31. When I was young I sometimes stole things.

____ 32. I have never dropped litter on the street.

____ 33. I have in the past sometimes driven faster than the speed limit.

____ 34. I never read trashy books or magazines.

____ 35. I have done things that I don't tell other people about.

____ 36. I never take things that don't belong to me.

____ 37. I have taken sick-leave from work or school even though I wasn't really sick.

____ 38. I have never damaged a library book or store merchandise without reporting it.

____ 39. I have some pretty awful habits.

____ 40. I don't gossip about other people's business.

Appendix X: Example of Overall 51-Item Master Copy Version of the Importance of Religious Ritual Scale

The following items measure how important religious ritual is to you. Please read each statement carefully and circle the response that best describes whether you agree or disagree with each item (e.g. 1 = Strongly disagree, 5 = Strongly agree).

		Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1	Attendance at church is an important part of my religious practice.	1	2	3	4	5
2	Religious ceremonies are an important part of my religious practice.	1	2	3	4	5
3	Prayer is an important part of my religious practice.	1	2	3	4	5
4	Receiving Holy Communion (the Lord's Supper, the Eucharist) is important to me.	1	2	3	4	5
5	Making the sign of the cross in church is important to me.	1	2	3	4	5
6	Using a prayer rope or set of beads (e.g. the rosary) is important to me.	1	2	3	4	5
7	Religious rites of passage (e.g. baptisms, confirmations, marriages, funerals) are important to me.	1	2	3	4	5
8	The role of religious ministers in religious ceremonies is important to me.	1	2	3	4	5
9	Kneeling or bowing in church is important to me.	1	2	3	4	5
10	Visiting or making pilgrimages to holy religious sites is important to me.	1	2	3	4	5
11	Visiting the grave site of friends, relatives, or lost loved ones is important to me.	1	2	3	4	5
12	Worship in church is an important part of my religious practice.	1	2	3	4	5
13	Fasting during religious festivals is an important part of my religious practice.	1	2	3	4	5
14	Singing in church is an important part of my religious practice.	1	2	3	4	5
15	The order, precision, and standardisation of religious ceremonies are important to me.	1	2	3	4	5

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
16	Making the sign of the cross with holy water when entering and leaving a church is important to me.	1	2	3	4	5
17	Religious contemplation and introspection are important parts of my religious practice.	1	2	3	4	5
18	Acts of worship and prayer calm me emotionally.	1	2	3	4	5
19	I feel closer to God during religious rituals.	1	2	3	4	5
20	Religious processions are important to me.	1	2	3	4	5
21	Engaging in religious rituals calm any worrying thoughts I have.	1	2	3	4	5
22	Venerating the 14 Stations of the Cross is important to me.	1	2	3	4	5
23	Through religious rituals I feel a greater sense of control over events in my life.	1	2	3	4	5
24	I feel closer to others through religious rituals.	1	2	3	4	5
25	I feel able to communicate with God through religious rituals.	1	2	3	4	5
26	Religious candle lighting is an important part of my religious practice.	1	2	3	4	5
27	Through religious rituals I feel I can influence God or other religious figures with divine qualities (e.g., saints, angels).	1	2	3	4	5
28	Through religious rituals I feel I can identify with God or religious figures.	1	2	3	4	5
29	I believe religious rituals are authorized by God.	1	2	3	4	5
30	Worship on annual holy days (e.g. midnight mass for Christmas) is an important part of my religious practice.	1	2	3	4	5
31	Religious rituals give me personal strength during times of difficulty.	1	2	3	4	5
32	Religious rituals strengthen or reaffirm my religious or spiritual beliefs.	1	2	3	4	5

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
33	Engagement in religious rituals can be a form of self-enhancement.	1	2	3	4	5
34	Venerating religious icons, crucifixes and relics of saints, is an important part of my religious practice.	1	2	3	4	5
35	The use of incense in religious ceremonies is important to me.	1	2	3	4	5
36	Religious rituals help me to express my inner thoughts or feelings.	1	2	3	4	5
37	Confession is an important part of my religious practice.	1	2	3	4	5
38	The use of music in religious ceremonies is important to me.	1	2	3	4	5
39	The conduct of religious ministers during religious ceremonies is important to me.	1	2	3	4	5
40	Meditation is an important part of my religious practice.	1	2	3	4	5
41	The saying of grace before meals is important to me.	1	2	3	4	5
42	Use of the sign of peace is important to me.	1	2	3	4	5
43	Meeting in small prayer groups is an important part of my religious practice.	1	2	3	4	5
44	Religious vestments are important to me.	1	2	3	4	5
45	I have used religious rituals to atone for possible sins I may have committed.	1	2	3	4	5
46	Periods of silence during acts of worship are important to me.	1	2	3	4	5
47	The role of lay ministers in religious ceremonies is important to me.	1	2	3	4	5
48	The repetition of words, prayers, songs, and actions during worship are important to me.	1	2	3	4	5
49	I find religious rituals reassuring and comforting.	1	2	3	4	5
50	Reading religious scripture (e.g. the Bible) is an important part of my religious practice.	1	2	3	4	5

51. If reading the Bible is an important part of your religious practice, please use the space below to write down which passages from the Bible are most important to you and why. If you cannot remember the chapter or verse please try and write a quote from the chapter or describe the general gist of the passage, and don't forget to say why it is important to you. (Please continue onto a separate sheet of paper if necessary).

Thank you for your time and patience

Appendix Y: Example of Importance of Religious Ritual Scale (38-Item Version)

The following items measure how important religious ritual is to you. **Please circle** the relevant response to indicate how much you agree or disagree with each item. **Please try to answer every item.**

		Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1	Attendance at church is an important part of my religious practice.	1	2	3	4	5
2	Religious ceremonies are an important part of my religious practice.	1	2	3	4	5
3	Prayer is an important part of my religious practice.	1	2	3	4	5
4	Receiving Holy Communion (the Lord's Supper, the Eucharist) is important to me.	1	2	3	4	5
5	Reading religious scripture (e.g. the Bible) is an important part of my religious practice.	1	2	3	4	5
6	Using a prayer rope or set of beads (e.g. the rosary) is important to me.	1	2	3	4	5
7	Religious rites of passage (e.g. baptisms, confirmations, marriages, funerals) are important to me.	1	2	3	4	5
8	Kneeling or bowing in church is important to me.	1	2	3	4	5
9	Making the sign of the cross is important to me.	1	2	3	4	5
10	Religious candle lighting is an important part of my religious practice.	1	2	3	4	5
11	The use of incense in religious ceremonies is important to me.	1	2	3	4	5
12	Fasting during religious festivals is an important part of my religious practice.	1	2	3	4	5
13	Singing in church is an important part of my religious practice.	1	2	3	4	5
14	Worship on annual holy days (e.g. midnight mass for Christmas) is an important part of my religious practice.	1	2	3	4	5
15	Venerating the 14 Stations of the Cross is important to me.	1	2	3	4	5
16	Venerating religious icons, crucifixes and relics of saints, is an important part of my religious practice.	1	2	3	4	5

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
17	The use of music in religious ceremonies is important to me.	1	2	3	4	5
18	Religious processions are important to me.	1	2	3	4	5
19	Confession is an important part of my religious practice.	1	2	3	4	5
20	The role of religious ministers in religious ceremonies is important to me.	1	2	3	4	5
21	Visiting or making pilgrimages to holy religious sites is important to me.	1	2	3	4	5
22	The order, precision, and standardisation of religious ceremonies are important to me.	1	2	3	4	5
23	Visiting the grave site of friends, relatives, or lost loved ones is important to me.	1	2	3	4	5
24	The conduct of religious ministers during religious ceremonies is important to me.	1	2	3	4	5
25	The saying of grace before meals is important to me.	1	2	3	4	5
26	I feel able to communicate with God through religious rituals.	1	2	3	4	5
27	Engaging in religious rituals calm any worrying thoughts I have.	1	2	3	4	5
28	Religious rituals give me personal strength during times of difficulty.	1	2	3	4	5
29	Religious rituals strengthen or reaffirm my religious or spiritual beliefs.	1	2	3	4	5
30	Through religious rituals I feel a greater sense of control over events in my life.	1	2	3	4	5
31	Religious rituals help me to express my inner thoughts or feelings.	1	2	3	4	5
32	I feel closer to God during religious rituals.	1	2	3	4	5
33	I feel closer to others through religious rituals.	1	2	3	4	5
34	Through religious rituals I feel I can identify with or influence religious deities or God.	1	2	3	4	5
35	I find religious rituals reassuring and comforting.	1	2	3	4	5
36	I believe religious rituals are authorized by God.	1	2	3	4	5

37	I have used religious rituals to atone for possible sins I may have committed.	1	2	3	4	5
38	Engagement in religious rituals can be a form of self-enhancement.	1	2	3	4	5

Appendix Z: Example of Study 4 Information/Consent Form

Questionnaire Survey Examining Coping and Adjustment to Bereavement

Statement of Consent

I am John Spreadbury a PhD researcher in the health research group in the School of Psychology at the University of Southampton. Thank you for expressing an interest in taking part in this research. I am requesting your participation in a study regarding the role played by personal beliefs, social support, subjective health status, and personality factors in the process of coping and adjusting to bereavement. This will involve completing a questionnaire asking you about your experience of bereavement and grief, your religious/spiritual beliefs and practices, your health perceptions, your access to social support, how you feel about close relationships, and a small number of background questions (e.g. age, gender). Completion of the questionnaire should take no longer than approximately 45 minutes. Personal information will not be released to or viewed by anyone other than the principal researcher involved in this project. Results of this study will not include your name or any other identifying characteristics.

Completion and return of this questionnaire will be taken as evidence of you giving informed consent to be included as a participant in this study, for your data to be used for the purposes of research, and that you understand that published results of this research project will maintain your confidentiality. Your participation is voluntary and you may withdraw your participation at any time. A summary of this research project will be supplied to me upon request.

If you have any questions and/or would like to request a project summary please contact me, John Spreadbury, at the School of Psychology, University of Southampton, Southampton, SO17 1BJ, or by telephone on (*details omitted*) or on (*details omitted*), or by email on Jhs101@soton.ac.uk.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 5578.

Appendix AA: Example of Study 4 Debriefing Form

Questionnaire Survey Examining Coping and Adjustment to Bereavement

Debriefing Statement

The aim of this research was to examine the influence of a range of psychosocial variables on the experience of grief and psychological well-being. We hope to examine the relative influence of religious variables such as belief and practice on the experience of grief in comparison with non-religious variables such as social support, subjective health status, and attachment style. It is expected that in addition to increased access to social support and better health being associated with lower levels of grief and increased psychological well-being, for some people important religious beliefs and practices may also contribute toward lower levels of grief. Your data will help our understanding of the range of psychological and social factors important in middle and later life that are related to coping and adjustment to bereavement and are associated with increased health and well-being. Once again results of this study will not include your name or any other identifying characteristics. The research did not use deception. You may have a copy of this summary if you wish. You may also have a summary of the research findings once this project is completed.

If you have any further questions please contact me, John Spreadbury, by telephone on (*details omitted*) or on (*details omitted*), or by email on Jhs101@soton.ac.uk; or by contacting Professor Peter Coleman by telephone on (*details omitted*) or by email on P.G.Coleman@soton.ac.uk.

If you would like further information or support about bereavement and coping with grief you can visit the Cruse Bereavement Care website on www.crusebereavementcare.org.uk or alternatively you can call the Cruse Bereavement Care helpline on 0844 477 9400. Cruse Bereavement Care is a nationally recognised organisation aimed at providing education, support, and advice on all issues related to bereavement.

Thank you for your participation in this research.

Signature _____ Date _____

Name

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 5578.

Appendix AB: Example of Study 4 Socio-Demographic Questionnaire

The following items are some general background questions.

1	What is your gender? (please circle)	Male	Female

2	What is your age? (please write in the box)	……..Years

3	How would you describe your race/ethnicity? (please circle)	White	Indian	Pakistani	Bangladeshi	Black Caribbean
		Black African	Black other	Chinese/South East Asian	Other, please state: ……	

4	What is your highest level of education? (please circle)	School	College	University	Postgraduate

5	What is your present employment status? (please circle)	Employed full time	Employed part time	Unemployed	Retired

6	In general, would you say your present financial situation is: (please circle)	Excellent	Very Good	Good	Fair	Poor

7	How long ago did your spouse or partner pass away? (please write in box)	

8	How long were you married to your spouse who recently passed away? (please write in box)	

9	How much forewarning did you have that your spouse was going to pass away? (please write in box)	…..Hours……Days……Weeks……Months.....Years

10	What was your spouse's cause of death? (please write in box)	

11	Were you the carer for your deceased spouse?	Yes	No

12	Have you remarried following your bereavement?	Yes	No

Appendix AC: Example of Inventory of Complicated Grief (ICG)

These items are about your experience of grief. Not everybody experiences these characteristics of grief, but for each item please indicate the answer that best describes **how you feel right now**. **Please try to answer every item.**

1	I think about this person so much that it's hard for me to do the things I normally do…	Never	Rarely	Sometimes	Often	Always
2	Memories of the person who died upset me…	Never	Rarely	Sometimes	Often	Always
3	I feel I cannot accept the death of the person who died…	Never	Rarely	Sometimes	Often	Always
4	I feel myself longing for the person who died…	Never	Rarely	Sometimes	Often	Always
5	I feel drawn to places and things associated with the person who died…	Never	Rarely	Sometimes	Often	Always
6	I can't help feeling angry about his/her death…	Never	Rarely	Sometimes	Often	Always
7	I feel disbelief over what happened…	Never	Rarely	Sometimes	Often	Always
8	I feel stunned or dazed over what happened…	Never	Rarely	Sometimes	Often	Always
9	Ever since s/he died it is hard for me to trust people…	Never	Rarely	Sometimes	Often	Always
10	Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about…	Never	Rarely	Sometimes	Often	Always
11	I have pain in the same area of my body or have some of the same symptoms as the person who died…	Never	Rarely	Sometimes	Often	Always
12	I go out of my way to avoid reminders of the person who died…	Never	Rarely	Sometimes	Often	Always
13	I feel that life is empty without the person who died…	Never	Rarely	Sometimes	Often	Always
14	I hear the voice of the person who died speak to me…	Never	Rarely	Sometimes	Often	Always
15	I see the person who died stand before me…	Never	Rarely	Sometimes	Often	Always
16	I feel that it is unfair that I should live when this person died…	Never	Rarely	Sometimes	Often	Always
17	I feel bitter over this person's death...	Never	Rarely	Sometimes	Often	Always
18	I feel envious of others who have not lost someone close…	Never	Rarely	Sometimes	Often	Always
19	I feel lonely a great deal of the time ever since s/he died…	Never	Rarely	Sometimes	Often	Always

Appendix AD: Example of Ritual Activities Subsection of the Bereavement Activities Questionnaire (BAQ)

Please tick all the activities below that you have participated in to help you cope with your grief over the loss of your spouse, then rate each activity as to how helpful you found the activity to be.

I have performed the following activities to help me deal with the loss of my spouse/partner:

			Very unhelpful	Not very helpful	Moderately helpful	Very helpful	Extremely helpful
1	□	A memorial service (other than the funeral).	1	2	3	4	5
2	□	A special meal in honour of deceased.	1	2	3	4	5
3	□	A remembrance ceremony or celebration designed or prescribed by someone else.	1	2	3	4	5
4	□	A remembrance ceremony or celebration designed by me.	1	2	3	4	5
5	□	Attending a bereavement support group.	1	2	3	4	5
6	□	Attending individual grief counselling or psychotherapy.	1	2	3	4	5
7	□	Dedicating something in memory of the deceased (a bench, a tree, etc).	1	2	3	4	5
8	□	Giving things to others in memory of the deceased.	1	2	3	4	5
9	□	Writing a letter or poem to the deceased.	1	2	3	4	5
10	□	Singing or playing music in honour of the deceased.	1	2	3	4	5
11	□	Creating something (memory book, collage, quilt, painting, etc.) in honour of the deceased.	1	2	3	4	5
12	□	Visiting a place that was special to the deceased.	1	2	3	4	5
13	□	Doing things that the deceased enjoyed that might not otherwise be appealing.	1	2	3	4	5
14	□	Lighting a candle in remembrance of the deceased.	1	2	3	4	5
15	□	Visiting the gravesite of the deceased.	1	2	3	4	5
16	□	Keeping a journal with thoughts about what has happened.	1	2	3	4	5
17	□	Visiting the place where my loved one died.	1	2	3	4	5
18	□	Displaying photo(s) of the deceased and / or showing them to others.	1	2	3	4	5
19	□	Sharing stories about the deceased with others.	1	2	3	4	5

			Very unhelpful	Not very helpful	Moderately helpful	Very helpful	Extremely helpful
20	□	Creating an altar or space in memory of the deceased.	1	2	3	4	5
21	□	Speaking to the deceased (to a photo, or otherwise).	1	2	3	4	5
22	□	Carrying or wearing something that is a reminder of the deceased.	1	2	3	4	5
23	□	Scattering of ashes at a special location.	1	2	3	4	5
24	□	Talking about my spouse with other people (e.g. children, grandchildren, friends) who knew him/her.	1	2	3	4	5
25	□	Dedicating more of my time to helping other people.	1	2	3	4	5
26	□	Other activity, please describe briefly …… ….	1	2	3	4	5

Appendix AE: Example of Anxiety Subsection of the Hospital Anxiety and Depression Scale (HAD-A)

For each item, please circle the reply which comes closest to how you have been feeling in the **past week**.

1	I feel tense or 'wound up':	Most of the time	A lot of the time	From time to time	Not at all
2	I get a sort of frightened feeling as if something awful is about to happen:	Very definitely and quite badly	Yes, but not too badly	A little, but it doesn't worry me	Not at all
3	Worrying thoughts go through my mind:	A great deal of the time	A lot of the time	From time to time but not too often	Only occasionally
4	I can sit at ease and feel relaxed:	Definitely	Usually	Not often	Not at all
5	I get a sort of frightened feeling like 'butterflies' in the stomach:	Not at all	Occasionally	Quite often	Very often
6	I feel restless as if I have to be on the move:	Very much Indeed	Quite a lot	Not very much	Not at all
7	I get sudden feelings of panic:	Very often	Quite often	Not very often	Not at all

Appendix AF: Example of Experiences in Close Relationship Scale Short-Form (ECR-S, Adapted Version)

The following statements are about how you feel in close relationships. We are interested in how you **generally** experience relationships, not just in what is happening in a current relationship. We recognise that you have experienced a recent bereavement so please just indicate how you generally experience close relationships. **Please circle the relevant response to indicate how much you agree or disagree with each item.**

		Strongly disagree	**Somewhat disagree**	**Neutral**	**Somewhat agree**	**Strongly agree**
1	It helps to turn to a close other person in times of need.	1	2	3	4	5
2	I need a lot of reassurance that I am loved by people close to me.	1	2	3	4	5
3	I want to get closer to other people, but I keep pulling back.	1	2	3	4	5
4	I find that other people in my life don't want to get as close as I would like.	1	2	3	4	5
5	I turn to close other people for many things, including comfort and reassurance.	1	2	3	4	5
6	My desire to be very close sometimes scares people away.	1	2	3	4	5
7	I try to avoid getting too close to other people in my life.	1	2	3	4	5
8	I do not often worry about being abandoned.	1	2	3	4	5
9	I usually discuss my problems and concerns with a close other person.	1	2	3	4	5
10	I get frustrated if close other people are not available when I need them.	1	2	3	4	5
11	I am nervous when other people in my life get too close to me.	1	2	3	4	5
12	I worry that close other people won't care about me as much as I care about them.	1	2	3	4	5

Appendix AG: Example of MOS Social Support Scale

Next are some questions about the support that is available to you.

1. About how many close friends and close relatives do you have (people you feel at ease with and can talk to about what is on your mind)? Please write in the space below the number of close friends and close relatives.…….....

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? **Please circle one number for each item.**

		None of the time	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
2	Someone to help you if you were confined to bed…	1	2	3	4	5
3	Someone you can count on to listen to you when you need to talk…	1	2	3	4	5
4	Someone to give you good advice about a crisis…	1	2	3	4	5
5	Someone to take you to the doctor if you needed it…	1	2	3	4	5
6	Someone who shows you love and affection…	1	2	3	4	5
7	Someone to have a good time with…	1	2	3	4	5
8	Someone to give you information to help you understand a situation…	1	2	3	4	5
9	Someone to confide in or talk to about yourself or your problems…	1	2	3	4	5
10	Someone who hugs you…	1	2	3	4	5
11	Someone to get together with for relaxation…	1	2	3	4	5
12	Someone to prepare your meals if you were unable to do it yourself…	1	2	3	4	5
13	Someone whose advice you really want…	1	2	3	4	5
14	Someone to do things with to help you get your mind off things…	1	2	3	4	5
15	Someone to help with daily chores if you were sick…	1	2	3	4	5

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
16	Someone to share your most private worries and fears with…	1	2	3	4	5
17	Someone to turn to for suggestions about how to deal with a personal problem…	1	2	3	4	5
18	Someone to do something enjoyable with…	1	2	3	4	5
19	Someone who understands your problems…	1	2	3	4	5
20	Someone to love and make you feel wanted…	1	2	3	4	5

Appendix AH: Example of Mood Repair Component

Pleasant Events and Activities

During the past 4 weeks did you engage in any of the following activities and find it enjoyable. Please tick one or more boxes.

- ☐ Being in the country
- ☐ Talking about sports
- ☐ Planning trips or vacations
- ☐ Reading stories, novels, poems, or plays
- ☐ Watching television
- ☐ Going to a party
- ☐ Going to church functions (socials, classes, bazaars etc.)
- ☐ Being with friends
- ☐ Gardening
- ☐ Dancing
- ☐ Having friends come to visit
- ☐ Going on outings (to the park, a picnic, a barbeque, etc.)
- ☐ Eating good meals
- ☐ Visiting friends
- ☐ Listening to music
- ☐ Playing sport
- ☐ Shopping
- ☐ Going for a walk
- ☐ Being with my children or grandchildren
- ☐ Travelling
- ☐ Attending a concert, opera, or ballet
- ☐ Playing with pets
- ☐ Seeing beautiful scenery
- ☐ Exercising (walking, dancing, etc.)
- ☐ Going to a museum or exhibit
- ☐ Other, please specify:……...

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