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Loma Linda University Graduate
School

The Effects of Parent's Religious Coping on
Children's Functioning after Loss

by

Beatrice A. Tauber

A Doctoral Project submitted in partial satisfaction of the requirements for the degree of
Doctor of Psychology

June 2004

2004
Beatrice A. Tauber
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Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a doctoral project for the degree of Doctor of Psychology.

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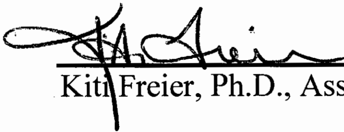

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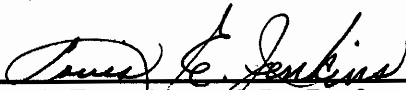

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ABSTRACT OF THE DISSERTATION

A Study of the Effects of Parent's Religious Coping Style on Children's Functioning after Parental Loss

by

Beatrice A. Tauber

Doctor of Clinical Psychology, Graduate Program in Psychology
Loma Linda University, June 2004
Dr. Kelly R. Morton, Chairperson

This study explored how parent's religious coping styles influence their child's behavioral reactions following spousal bereavement. Fifteen participants were recruited from churches, bereavement groups, hospices, palliative care programs and from victims of the September 11, 2001 terrorist attacks. Individuals who lost a spouse within the past 3 years and who had a child between the ages of 7 and 14 years participated. Parents described the religious coping strategies they employed after the loss of their spouse on Pargament's Brief Religious Coping Scale as well as the symptoms of their child on the Child Behavior Checklist. Pearson correlations demonstrated a significant negative relationship between positive religious coping and externalization of symptoms, as well as a significant positive relationship between negative religious coping and externalization of symptoms. Finally, though the sample is small, a number of additional patterns emerged revealing that several death context variables had an impact on child adjustment.

Introduction

In the year 2001 we saw the impact of devastation and the loss of human life. Although the terrorist attacks of September 11, 2001 brought a diverse array of feelings, none compares so profoundly to the images of fathers and mothers going to work on Tuesday morning, but not returning home that evening to their waiting children. The death of a parent can be one of the most painful losses experienced by a child. One school of thought maintains that children do not proceed through a grieving process until the adolescent years. Researchers such as Wolfenstein (1966) state that the capacity to mourn is not acquired until adolescence when the self is fully differentiated. The present study is based on the belief that children do have the capacity to grieve. If children have the capacity to attach to a primary caretaker (Bowlby, 1980), then separation from this primary caretaker can and does result in a grief response.

When a family member dies, the coping style of the remaining family members is a critical factor for a child's grief process and we posit that this is impacted by religious beliefs and values. In the United States, over 90% of people who responded to the largest national survey conducted on religious affiliation identified themselves as religious (Goldman, 1991). Acknowledgement of a religious affiliation has never been more evident than after September 11, 2001, when two phenomena emerged. First, America had been attacked and Americans united to defend their country. Second, people began a search for meaning and support in a time of crisis. On the night of the attacks, President Bush (2001) addressed the nation, "Tonight I ask for your prayers for all those who grieve, for the children whose worlds have been shattered, for all whose sense of safety and security has been threatened. I pray they will be comforted by a power greater than

any of us, spoken through the ages in Psalm 23: 'Even though I walk through the valley of the shadow of death, I fear no evil, for You are with me'". After September 11th, people responded as they often do in times of intense loss and crisis, by seeking solace through their religious beliefs to help them cope. This study examined how religion leads to a coping process. More specifically, the findings addressed whether positive religious coping leads to a more adaptive coping style in surviving parents and to less externalizing and internalizing of symptoms in children following the death of their parent and whether negative religious coping adversely effects these same domains. A correlational design was used for this study and correlations between parental religiosity and amount of externalizing and internalizing of symptoms in children was examined.

Background of the Problem

There are numerous mediators that influence the course and outcome of loss; one important mediator suggested in the literature is the use of religious coping. Gorer (1965) states that the contemporary decline in accepted ritual and religious guidance after bereavement is responsible for a considerable amount of maladaptive behavior. Gorer indicates that the failure to engage in guided mourning, which may be facilitated by religion, is likely to be followed by lasting depression, impaired relationships, and irrational attitudes toward death. Parkes and Weiss (1983) confirm this finding by demonstrating that the overt expression of grief provides a framework for an adaptive grief process. Thus, a lack of a framework for the use of ritual and religious guidance is detrimental to those experiencing grief.

Purpose and Importance of the Study

The use of religious coping after the death of a spouse may mediate the effects of externalizing and internalizing symptoms found in children after the death of a parent. Surveys find that as many as 90% of people interviewed will identify themselves as religious (Goldman, 1991). Examining the impact of religion on an individual's life is therefore a crucial component toward a more comprehensive understanding of human behavior.

Research examining the psychological consequences of the use of religion during times of stress is scarce. A literature search of the PsycINFO database reveals that only about 1% of all articles on coping with stressful life events include a religion component (Tix & Frazier, 1998). Although these numbers are increasing, the field of psychological research lacks empirical evidence regarding the effects of religion on coping. The examination of the psychological consequences of the use of religion during times of stress, such as the death of a parent, is therefore a needed area of research.

Understanding the role that religion plays in coping with the death of a parent with subsequent effects on the surviving children is an especially relevant topic of research to be completed at Loma Linda University. Loma Linda University adheres to a mission statement of wholeness in which the physical, mental, and spiritual life of a person is considered to be the basis of all treatment and educational pursuits.

Procedural Overview

Religious coping theory provided the constructs, operational definitions under examination and an established explanatory context.

Two instruments were used in this study: the Brief Religious Coping Scale, and the Child Behavior Checklist. These instruments were selected as reliable and valid measures for the constructs of interest.

Data collection was done using questionnaires. Data analysis was accomplished using both quantitative and qualitative procedures. A correlational design was employed to analyze the association between the independent and dependant variables. An inherent limitation of a correlational design is that change within an individual is not directly measured over time and cause and effect relationships can not be assumed as third variables not measured may be influencing the observed relationships.

Theoretical Foundation

An explanatory model for the utility of religious coping theory as a dimension moderating the effect of stress after loss is provided by Pargament, Smith, Koenig, Perez (1998). Methods of religious coping add unique variance to the prediction of health and well-being above and beyond the effects of measures of nonreligious coping. Religious coping methods mediate the relationships between an individual's general religious orientation and the outcomes of major life stresses. When faced with a stressful event, general religious beliefs and practices translate into specific forms of coping and it is these specific coping methods that appear to have the most direct implications for the individual's health and adjustment during stressful times. This view of religious coping is a multidimensional view. It assists people in the search for a variety of significant ends during stressful times such as in a person's sense of meaning and purpose, emotional comfort, personal control, intimacy with others, physical health and spirituality. Specific religious coping methods used by persons include the use of spiritual support, religious

acts such as purification and forgiveness, and religious reappraisals that lead to meaning making and purpose during times of stress. The multidimensionality of religious coping will be further described in the following sections.

Children's Grief Process

Children grieve after the loss of a parent. This assumption is based on Bowlby's (1980) attachment theory and conceptual framework. Attachment behavior is conceived as any form of behavior that results in a person attaining or retaining proximity to some other differentiated and preferred individual. The figure to which a child attaches can be the mother, father, sibling, or significant other. Attachment behavior is seen as characteristic of all humans and is necessary for survival. These behaviors keep the child in touch with a primary caretaker, provide for security and physical needs, and can provide for a set of schemas or templates about relationships that the child will carry throughout life. A child's basic needs, such as food, water, and nurturance, are all provided by the parent. The parent also provides an environment in which the child is safe to learn and explore. The parent maintains a safe environment by setting up boundaries and structure within which the child learns. Securely attached children will be free to explore and learn within the safety of a structured environment created by the parent. Therefore, when a primary caretaker in a child's life dies, the child must cope with the loss of the figure who provided this necessary relationship in a secure environment.

Every child is unique. A child's grief will likewise be unique. According to Tremblay and Israel (1998), the grief process shouldn't be conceptualized as a single event. Rather, it is more useful to conceptualize loss as an "extended and multifaceted

process, whose impact on survivors is strongly influenced by surrounding circumstances and stressors"(p. 427). This process is multifaceted in that many factors impact grief. Not only does the child bring his or her own unique character to the process, but the surviving parent and their social support system will also impact the process. Roles once fulfilled by the deceased, need once again to be fulfilled. How the various roles once performed by the deceased are fulfilled, reshaped, or left vacant are widely believed to effect a child's adjustment following the death of a parent (Tremblay & Israel, 1998). In order to understand this multifaceted process, it is necessary to provide a definition of grief, understand the tasks of grieving, and to delineate the adaptive grief reactions children have following a death.

Grief defined. Grief and bereavement are two commonly used terms to describe the process a child experiences after the death of a parent. Grief is defined as the emotional reaction to loss. It is commonly used to identify a bereaved person's reaction to loss (Corr, 2000). Bereavement is the objective situation of someone who is experiencing a significant loss. If bereavement is the objective situation, then grief is the subjective or personal reaction to that situation (Corr, 2000). Thus, grief is the bereaved person's response to a significant person no longer physically existing in their life.

Tasks of grieving. Children and adults both have a personal reaction to loss. Worden (1996) defines four tasks necessary for both children and adults to adapt to a loss. The child's approach to each of these tasks is dependant upon their developmental level.

Worden (1996) identifies the first task as accepting the reality of the loss. The concept of irreversibility is a necessary component of this task. Irreversibility, in this

context, is an understanding that once someone is dead they will not come to life again (Papalia & Olds, 1992). Children begin to understand this concept between 5 to 7years of age.

The second task is to work through the intensely painful feelings of loss associated with grief. In order to work through the painful feelings of loss, a child must first recognize the irreversibility of death. Prior to 5 years of age, children still view death as reversible. They think that their mother or father still physically exists and can show up at any time. Young children function at what Piaget (1951) termed the preoperational level of development. At this stage, the child will not recognize the irreversibility of death. Children between the ages of 5 to 7 years begin to understand the concept of irreversibility because they have the cognitive developmental skills that enable them to understand something of the permanency of death, but they lack the ego and social skills to deal with the intensity of the feelings of loss (Worden, 1996). They may have difficulty dealing with the painful emotional experience of parental loss and may be a particularly vulnerable group (Herr, 1999; Worden, 1996). Worden (1996) provides the experience of a 6-year-old girl who began having nightmares and high levels of anxiety after she learned her mother only had six months to live. Her brother and sister, 3 and 13 years of age, did not experience such anxiety. Although she was placed in situations, like Sunday school, in which she learned about death, her high levels of anxiety continued after the death of her mother.

Beginning around 8 years of age, children not only begin to understand the concept of irreversibility, but they also understand the concept of universality, and nonfunctioning (Papalia & Olds, 1992). Universality includes an understanding that all

living things die. Understanding that a dead person is nonfunctional means comprehending that all life functions end at death. According to Piaget (1954), understanding these concepts develops when children move from preoperational to concrete operational thinking. Therefore, children between the ages of 8 and 12 years are in the stage where they are developing the cognitive capacity for concrete operations. This capacity enables the child to experience and react to the loss of a parent. Children at this age will look to their surviving parent as a model for how to deal with their feelings and will be able to experience and process their own feelings.

Third, the child must adjust to an environment in which the deceased is missing. This is an example of the multifaceted grief process. The child must adjust to the fact that the various roles once fulfilled by the deceased parent may be filled by someone else, reshaped, or left vacant (Tremblay & Israel, 1998). For example, a father may die when his daughter is 8 years old. As the daughter grows older, she will continually need to adjust to an environment in which her father is not there for events such as birthdays and/or her wedding day.

The final task is to relocate the dead person within one's life and to find ways to memorialize the person. The task facing the child is to recognize their parent no longer physically exists in their life and to find a new and appropriate way to remember the dead in their life. The child must move forward with their life, while keeping the memory of the deceased parent alive (Schwab, 1997). A child must be helped to transform the connection to the dead parent and to place the relationship in a new perspective rather than separate from the deceased (Worden, 1996).

The course of grief reactions. All children will exhibit some form of a grief reaction after the death of a parent. Some of the most common expressions of grief include crying, sadness, anger, guilt, and despair, gloomy mood, sobbing and tearfulness, longing, and continued preoccupation on the subject of death (Dowdney, 2000; Kaffman & Elizure, 1996). Grief reactions can be defined as all of the affective responses of the bereaved child (Kaffman & Elizur, 1996).

Grief reactions are not random or haphazard reactions. Kaffman and Elizur (1996) outline a course of grief reactions. In the first few months after the death of a parent, children react with crying, sadness, and varied expressions of longing. Responses of anger, protest, and pain are also common. At the same time, and to an increasing extent throughout the first year after the death, the child begins to examine the meaning and the implications of the death of their parent. Children may ask many questions to gain an understanding of the difference between being "dead" and "alive". Children between the ages of 8 and 12 years will respond by translating the concept of the death of their parent into the concrete reality that their parent is no longer alive. Kaffman and Elizur (1996) find that attempts to understand the concept of death enables the child to accept the fact of death and come to terms with the many areas of uncertainty that threaten their world.

Most children around 8 years old and older will achieve acceptance that the loss of their parent is final. The painful understanding of the finality of the loss may bring significant increases in the child's level of anxiety. This increased anxiety is expressed by the appearance of various fears. These fears include being left alone, apprehension that the surviving parent may suddenly disappear, as well as fears of injury and darkness.

The most common of these was the fear of being left alone (Kaffman & Elizure, 1996). Thus, a common coping reaction during this period of anxiety is increased dependence on the surviving parent or on other significant adults.

Children also exhibit externalizing symptoms like aggression and internalizing symptoms like depression and concentration difficulties during this time period. Aggressive expressions are found significantly more often among boys, whereas girls exhibit more internalizing symptoms (Dowdney, Wilson, Maughan, Allerton, Schofield, Skuse, 1999; Kaffman & Elizur, 1996).

Finally, by the third and fourth year after a parental death, most children evidence symptomatic improvement and adjustment to the changed life circumstances (Kaffman & Elizur, 1996). At this point, there is a drastic decline in all areas of grief reactions, including anxiety, fears, overdependence, and aggression. Despite this general trend of improvement noted for most children, 28% of bereaved children continue to evidence problem scores in the clinically significant range (Dowdney et al., 1999).

It has been shown that most children process the loss of a parent in a healthy manner. However, by the third and fourth year after the loss, 28% of children continue to show signs of marked emotional impairment (Dowdney et al., 1999) and during the first two years after the death of a parent, 33% of children are at risk for developing high levels of externalizing and internalizing symptoms (Worden, 1996). In order to understand what differentiates children who process the loss of a parent in a healthy manner from those who are at risk for developing and maintaining externalizing and internalizing symptoms, different factors have been shown to mediate the risk for the development or continuation of these symptoms. The literature points to four specific

factors which mediate the manner in which a child will proceed through the grief process. First, the causes and circumstances surrounding the death (Worden, 1996) mediate grief reactions. Specifically, how the primary figure died, what the child has been told about the death, how much the child participated in the funeral and surrounding events, and if they are told the truth about the death are all important. Second, the personal characteristics of the child at the time of the death mediate grief reactions (Dowdney, 2000). This includes the child's age, gender, and temperament. Third, the relationship of the child to the primary caretaker before the death impacts grief (Worden, 1996). Fourth, the coping style of the surviving parent including the use of religious coping by the surviving parent impacts grief. The sections which follow delineate the empirical evidence regarding each of these mediators of children's grief reactions.

Causes and circumstances surrounding the death. Research shows that the distinctive nature of some deaths can effect the course of the grief reaction for adults and children. Sudden and unexpected deaths heighten surprise, intensify shock and numbness, and can leave the survivor with feelings of unfinished business (Attig, 1996). Witnessing a violent, mutilating death or suicide can exacerbate and add the challenges of a posttraumatic stress and can lead to the negative effects from the intrusion of law-enforcement agencies, the criminal justice system and the media (Attig, 1996; Doka, 1996). When a parent dies by homicide or suicide, children likewise exhibit a higher co-occurrence of disorders such as depression and post-traumatic stress, which lead to greater difficulties in dealing with the death (Dowdney, 2000). Death by homicide or suicide influences behaviors following parental death and complicates the mourning process in children (Osterweis, Solomon & Green, 1984).

All of these factors highlight that each loss, whether sudden, traumatic or expected will effect the survivors in very different and unique ways. Each loss may have factors that complicate as well as facilitate the grief process. One common theme that emerges as a complicating factor for children grieving is how and what the child is told about the death of the loved one.

Research has shown that confusion and pathology result when the news of a parent's death is withheld from the child, or is glossed over, and when the expression of feeling is discouraged either implicitly or explicitly (Bowlby, 1980). Cain and Fast (1972) studied 45 children, ages 4 to 14, who had lost a parent by suicide. Almost all of these children had been seen for diagnostic evaluation and/or treatment in a child guidance setting with symptoms ranging from running away to learning disabilities. After parental suicide they exhibited a variety of pathology. Children's symptomatology seemed to be rooted in two factors. The children experienced intense guilt that was elicited by the surviving parent and the communications between parent and child were characterized by distortions regarding the facts surrounding the death. One quarter of the children in the study had personally witnessed some aspect of the parent's death and were pressured by the surviving parent to believe that they were mistaken in what they had seen or heard. In these examples, the surviving parent told the child that the death had not been a suicide, but was caused by some illness or accident. As an example, a boy who watched his father kill himself with a shotgun was told later that night by his mother that his father died of a heart attack. Cain and Fast (1964) found similar results with children who had experienced the death of a sibling. It should be noted that almost all of

the children in the Cain and Fast studies were from a clinical sample, differentiating their sample from the present non-clinical sample.

Bowlby (1988) describes incidents, such as the previous ones, as following a pattern in which the surviving parent seeks to discredit what the child actually sees or feels, by ridiculing or insisting that the child was confused. This confusion is sometimes compounded by the child hearing several different stories about the death from different people, or even hearing different stories about the same death from the surviving parent. Many of the children's psychological problems seem to be directly traceable to having been exposed to situations of these kinds. Their problems include chronic distrust of other people, inhibition of their curiosity, distrust of their own senses, and a tendency to find everything unreal.

Sudden bereavement has been shown to complicate the bereavement process, but this does not seem true for most children (Herr, 1999). The Child Bereavement Study included children between the ages of 6 and 17 who had lost a parent to death. It involved a non-clinical representative community sample, interviews with both the surviving parent and all school-aged children in the family, following the family for 2 years post-loss, and assessed a matched non-bereaved sample of children (Worden, 1996). Worden notes that whether a parent died an unexpected or an anticipated death, had no influence on how the child adapted to the loss of a parent (Silverman & Worden, 1993). Rather, how the child understood what caused the death seemed to effect adjustment (Silverman, 2000). As previously demonstrated, open, honest, age appropriate communication facilitated adjustment more than the cause of death.

Finally, it has been shown that the manner in which a child participates in the funeral ceremony can mediate the grieving process. A child's age appropriate participation in the funeral can help meet three important needs for the child. It provides a setting to acknowledge the reality of the loss, gives an opportunity to honor the dead parent, and provides a means of external support for the child (Silverman & Worden, 1992). The funeral is a place that provides an environment to mediate grief reactions. Children who were not included in the funeral planning or were given little preparation for the funeral itself were found at risk two years after the death of a parent (Worden, 1996). These children were more likely to show disturbed behavior, low self-esteem, and were likely to experience more difficulty talking about the dead parent two years after the loss.

Personal characteristics of the child. A second factor that is cited as influencing the grieving process of a child includes the personal characteristics of the child such as age, gender, and temperament. Parental death will have a differential impact according to the age of the child. Specifically, children between 6 to 12 years of age were found to experience more social problems, cry more frequently, and to have more health problems following the death of a parent (Worden, 1996) than children in other age groups. In addition, bereaved boys exhibit more aggressive and acting-out behaviors than girls (Dowdney, 2000; Kaffman & Elizur, 1996). While the age and gender of the child have an impact on the experience of the loss and the child's adaptation to the death of a parent, they are not significant enough to predict risk or "pathological bereavement" (Worden, 1996; Kaffman & Elizur, 1996).

One last personal characteristic that plays a mediating role in the grief process is the child's temperament. It has been shown that children as young as 3 years fit into different temperament groups and that a childhood temperament is generally stable over time (Newman, Caspi, Moffitt & Silva, 1997). In addition, temperament is predictive of internalizing and externalizing problems in adulthood. In a longitudinal study, Bates, Pettit and Dodge (1995) found that infant characteristics such as hyper reactivity, impulsivity and difficult temperament significantly predicted externalization problems 10 years later. As with age and gender, there is ample evidence suggesting that the quality of parenting can mediate the association between early temperament characteristics and later internalizing and externalizing symptoms (Bates, Pettite, Dodge & Ridge, 1998).

Relationship to the primary caretaker before the death. A third factor that plays a mediating role in a child's grieving process includes the relationship the child had with the deceased prior to the death. The quality of the preexisting relationship with the deceased is linked to post-loss adjustment. If a parent dies while a child is young, the person to whom the child has attached has died. Unlike an adult or an adolescent, who may have a number of close relationships outside the family, a child may have only an attachment relationship with their parents. The younger the child, the more dependent they are on their parents for survival (Osterweis et al., 1984).

The nature of the relationship is of key importance. Just as is true of adults, a relationship that is marked by difficulties when the parent is alive, will likely result in continued difficulties for the child when the parent dies. For example, hostility toward a deceased parent may lead to defensive behaviors, such as idealization of the deceased, which runs counter to the resolution and completion of grief (Osterweis et al., 1984). It is

more likely that the potential of a conflicted relationship pre-loss will be found in a parent-adolescent relationship than a parent- preadolescent relationship since teenagers are typically moving toward independence that may foster relationship conflict (Wolfelt, 2000).

Finally, it has been shown that a child may show more emotional and behavioral problems following the death of a mother while preteen boys exhibit more behavioral problems after the loss of a father (Worden, 1996). Repeated emphasis is on the importance of the quality of the preexisting relationship.

Surviving parent's coping style. A fourth factor that plays a mediating role in a child's grief process is the surviving parent's coping style. How the adults who are closest to a child respond to the death of a loved one has been termed the most important factor in how children react to a death (Wolfelt, 2000). The parental response will be more fully developed and explained as the process of coping in the next section. One particular area of coping, religious coping, will be shown to be a particularly useful coping tool after the death of a parent.

Coping

There was a time in the history of psychology when psychologists believed that the mind was a "black box" and unobservable. The activity in the mind that occurred between stimuli and response was not measurable. The cognitive revolution in the 1970's brought recognition to the intrapsychic processes that can intervene between stimuli and response. It also brought an emphasis on conscious and observable adaptational efforts. Coping became the construct to explain these adaptational efforts

and was one of several psychosocial factors posited to mediate the relationship between stress and illness (Somerfield & McCrae, 2000).

Since the 1970's, coping has become one of the most widely studied topics in psychology. Folkman and Lazarus (1980) defined coping by distinguishing two forms of the coping process. Some coping processes are action-centered and are called problem-focused coping. These are the coping efforts aimed at the perceived source of stress. If a husband loses his wife by death, he may assume the parenting role once held by his wife by taking on tasks such as bathing and dressing the children. This is a form of problem-focused coping. As the husband continues to feel distress over the death of his wife, he will turn to a second form of coping called emotion-focused coping. Emotion-focused coping is otherwise known as the efforts to regulate one's emotions as a way of adapting to a stressful encounter (Folkman & Lazarus, 1980). A person may not be able to change a stressful situation, but they can change the meaning and therefore their emotional reaction to the situation (Lazarus, 1991). In the former example of the father coping with the loss of his wife, he may find comfort in reinterpreting the death of his wife.

Historically, coping has most often been evaluated in relation to its effectiveness in regulating stress. Coping can be defined as the constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding one's resources (Lazarus & Folkman, 1984). Coping has also been defined as any response to external life strains that serves to prevent, avoid, or control emotional distress (Pearlin & Schooler, 1978). The focus of research has been to link stress and coping by asking how individual efforts to manage distressing problems

and emotions effect the physical and psychological outcomes of stress (Somerfield & McCrae, 2000).

For coping research to be clinically useful, research needs to go beyond definitions of coping to highlight what is effective versus ineffective coping. Most commonly, researchers have relied on global, nonspecific adaptational outcomes such as negative affect or similar pathological outcomes as measures of coping (Somerfield & McCrae, 2000). For three decades, research has focused on an outcome model of coping. More specifically, research focused on the absence of pathology or illness as an outcome measure of effective coping. Research also focused on the benefits of problem versus emotion-focused coping though effective coping is a combination of problem and emotion-focused coping. Problem and emotion focused coping are conceptually distinguishable, but both strategies are interdependent, work together, one supplementing the other in the overall coping process (Lazarus, 200). For coping to be effective a person will utilize both forms of coping during a stressful situation.

Currently, research focuses on the use of both problem and emotion-focused coping. It also recognizes the positive outcomes to stress (Park, Cohen, & Much, 1996), meaning-based and meaning-making coping (Folkman & Moskowitz, 2000, Park & Folkman, 1997) and growth-oriented functioning during crisis situations (Pargament, 1998). These coping efforts go beyond managing the distressing event, to positive appraisals by the individual, tapping into a higher source or support system during times of stress, and leads to personal growth as a result of the stressful event.

This newer perspective of coping is multidimensional. Coping becomes the relational meaning that an individual constructs from the person-environment

relationship. That relationship is a result of the appraisals of the confluence of the social and physical environment with personal goals and beliefs about the self, world, and resources (Lazarus, 2000). It involves the interaction of each aspect of the person including social, spiritual, behavioral, emotional, intellectual, psychological and biological aspects.

Re-characterization of tasks as facets of coping. Attig (1996) brings another dimension to the tasks of grieving. He identifies the tasks of grief as important facets of coping. The first task, accepting the reality of the loss corresponds to the intellectual and spiritual facet of persons coping in which the person struggles to take in the reality of the death and make sense of the loss. The second task, to work through the intensely painful feelings of the loss, correspond with the emotional and psychological aspects of coping in which the person begins to acknowledge, express and process their feelings. The third task, adjusting to the environment in which the deceased is missing, corresponds to the behavioral facets of coping as the person explores and adopts the life changes that the loss demands. During the final task, relocating the dead person within one's life, corresponds to the social and spiritual facet of coping as the person finds a new way to relate to the deceased person and accommodate to the loss of the relationship with fellow survivors.

By re-characterizing the tasks of grieving as facets of coping one can see that each aspect of the coping process after loss involves the whole person. It involves the social, spiritual, behavioral, emotional, intellectual, psychological and biological aspects of the person. Therefore the process of coping after loss must address each of these aspects.

Religion and Coping. Before a death occurs, the surviving parent has an established orienting system or a general way of perceiving and dealing with the world. It consists of values, habits, generalized beliefs, relationships, and personality (Pargament, 1997). It is not only a frame of reference that is used to anticipate and come to terms with events in one's life, but also a resource drawn upon in times of stress (Pargament, 1998).

A person may utilize religion as part of their orienting system. Religion is measured as a stable, global, personal disposition, a part of an individual's orienting system (Pargament, 1998). A religious orienting system provides a general frame of reference during times of stress. A person's religious orienting system therefore gives an overall framework as to how a person utilizes religion in their life. Knowing that a person has a religious orienting system tells us that this type of person may utilize religion to help them cope, but it doesn't tell us how a person may use their religion to help them cope. Measures of religious coping are needed to specifically evaluate the cognitive and/or behavioral techniques that arise out of one's religion.

Religious coping can be defined as the use of cognitive and/or behavioral techniques, in the face of stressful life events, that arise out of one's religion or spirituality (Tix & Frazier, 1998). Two patterns of religious coping emerge from the techniques used by people. One pattern of religious coping is the use of cognitive and behavioral techniques that result in helpful or beneficial outcomes. The other pattern results in negative or harmful outcomes. Those religious coping methods that result in helpful or beneficial outcomes can be labeled as a pattern of positive religious coping. Positive religious coping is defined as an expression of a sense of spirituality, a secure

relationship with God, a belief that there is meaning to be found in life, and a sense of connectedness with others (Pargament et al., 1998). Positive religious coping may provide a multitude of benefits such as comfort, personal growth stimulation, a sense of intimacy with God, closeness with others, or meaning and purpose in life (Pargament & Park, 1995). A growing number of studies demonstrate the benefits of religious coping. Positive religious coping, for example, is linked to greater overall mental health and positive well-being for cancer patients (Ell, Mantell, Hamovitch, & Nishimoto, 1989). It has also been linked to stress-related growth during traumatic events such as the Oklahoma City bombing (Pargament et al., 1998) and is related to fewer depressive symptoms for medically ill patients (Koenig, 1998).

A number of studies have gone beyond highlighting the benefits of positive religious coping to try to determine why positive religious coping is effective. Parents who lost an infant to Sudden Infant Death Syndrome were interviewed 3 weeks and 18 months post loss. Greater religious participation was related to increased perception of social support and greater meaning found in the loss. Importance of religion was positively related to cognitive processing and finding meaning in the death. Furthermore, through these coping process variables, religious participation and importance were indirectly related to greater well-being and less distress among parents 18 months after their infants' death (McIntosh, Sliver & Wortman, 1993). Social support and positive reinterpretation were also found to mediate the relationship between religiosity measures and psychological outcomes in response to the death of a close friend (Park & Cohen, 1993).

Thus far it has been shown that individuals can benefit from embracing a positive religious coping style. Conversely, some forms of religiosity are not helpful or provide mixed evidence for a person's coping. People who report a less secure relationship with God have a tenuous and ominous view of the world and may experience a religious struggle in the search for meaning during a time of crisis. These individuals are more likely to demonstrate a detrimental coping pattern (Pargament et al., 1998). These are people who feel anger toward God, believe they are being punished for sins, and perceive a lack of emotional support from their church or synagogue. The people who report greater dissatisfaction with clergy, congregation members, and the deity also report poorer mental health status, more negative mood, and a poorer resolution to the negative life event (Pargament, 1997).

As stated earlier, religious coping can be described as a pattern. Most people who describe themselves as religious will utilize both positive and negative coping methods. Those people who use more positive religious coping methods than negative ones, can be described as using positive religious coping and have been shown to reap the benefits of this form of coping.

Religiosity and the coping style of the surviving parent. Parents are powerful sources of influence during children's growth and development (Schwab, 1997). It has been shown that after the death of a parent, the circumstances surrounding the death, personal characteristics of the child, the relationship to the deceased prior to death, and the surviving parent's coping all mediate the functioning of a child after the death of a parent. The coping style of the surviving parent, however is likely one of the most significant of these mediators regarding the child's adaption to the loss of a parent. Many

of the behaviors exhibited by bereaved children may disappear as parents start to restore their functioning and the family establishes new stability (Schwab, 1997).

Parental death is best understood as creating a vulnerability in the parentally bereaved child (Tremblay & Israel, 1998). The death of a parent is not necessarily followed by a pathological reaction or behavioral difficulties. Although the death of a parent will alter a child's life, it alone does not lead to behavioral difficulties. Children appear to be at risk for concurrent and later difficulties primarily to the extent that they suffer a higher probability of inadequate parental functioning or other environmental support before, as well as after, the loss of a parent (Tremblay & Israel, 1998).

How does religious coping aid parental functioning after the death of a spouse? Religious coping adds something to the coping process that nonreligious coping does not offer. A person who uses religious coping is also taping into a built in framework that already exists. As mentioned previously, a person already has a religious orienting system before they are faced with a death. This orienting system will be drawn on in times of crisis.

Religious coping provides unique benefits to the grieving parent and the parentally bereaved child. Religious communities in their basic makeup provide a social support network accessible to all their members. This is an example of religions ability to aid in problem-focused coping. Parents who have a religious orientation have direct access to the church and its members. Access to the church and its members means that members step in during times of crisis when the bereaved spouse feels alone and unable to provide a supportive environment for the parentally bereaved child. Membership provides support from fellow church members, helps the surviving parent see God as a

partner who works with them to resolve problems, and aids in viewing stressful situations as an opportunity for growth. The surviving parent who sees God as a partner is said to have a collaborative religious coping style. This coping style may allow the surviving parent to maintain an internal locus of control and simultaneously sustain the belief that God is helping and guiding them. This combination of internality and trust in God may be a particularly strong combination of control beliefs that help religious people maintain health and recover more quickly and effectively from life stress (Koenig, McCullough & Larson (2001).

Secondly, religious coping provides an avenue of help in shifting from anger, hurt, and fear associated with any unfinished business or offenses to peace prior to the death (Pargament, Koenig & Perez, in press) through the concept of forgiveness. Many religions further provide acts of religious purification that help the individual in asking for or obtaining forgiveness. The provision of forgiveness is an important part of the grief process. A parent may feel as if they have unfinished business with their deceased spouse or may be struggling with guilt over spoken words and acts that they wish they had never committed. The act of forgiveness allows the person to cease to bear resentment against another (Webster's Dictionary, 1997). Forgiveness allows the parent to relinquish the resentments they feel toward their deceased spouse as well as provides an example and a vehicle for the surviving children to relinquish the resentments they may hold against their parent (James, Friedman & Landon-Matthews, 2001).

Thirdly, religious coping provides access to the sacred, a unique source of power and strength. It also provides for an emotion-focused way of coping by providing answers that can help facilitate cognitive restructuring of the many questions and painful

feelings that remain after a death. This will be further explained in the following sections.

The outcome of a supportive environment provided by a religious affiliation and access to its members has also been shown to lead to more cohesive family relationships, lower levels of conflict in the family and fewer behavioral symptoms in children. In a study of parental religiosity, family processes, and youth competence in rural, two-parent, African-American families, it was shown that greater parental religiosity led to more cohesive family relationships, lower level's of interparental conflict, and fewer externalizing and internalizing symptoms in 9 -12 year olds. Formal religiosity also indirectly influenced youth self-regulation through its positive relationship with family cohesion and negative relationship with interparental conflict (Brody, Stoneman & Flor, 1996). This study was based on evidence that the church contributes to cohesion in the African-American community by acting as an agency of moral guidance and center for community life (Taylor & Chatters, 1991). It was also based on research indicating that religious beliefs and church attendance form an important coping mechanism for negotiating the life stresses that rural African-Americans are likely to experience (Krause & Tran, 1989).

In the longitudinal Child Bereavement Study, Worden (1996) defines cohesive families as including parents who rated their marriage as strong and were less likely to be dating soon after the death of a spouse. Although the surviving spouse in these families experienced the stress of the death, they were not necessarily depressed and rated their coping styles as good. Their coping strategies often involved redefinition and showed an absence of passivity. These parents took an active role in defining what life would be

like without their partner. These parents also reported that they found a new source of support and derived comfort from their religious beliefs.

Religion offers both a problem and emotion-focused way of coping. Children will have questions about why their parent has died and they will look to the surviving parent for guidance on what to believe about the causes of the death. A parent who has looked at their own beliefs about death and dealing with the loss will be able to pass on that information to their children. In doing so, their child will be able to deal more effectively with the loss (James et al., 2001).

Religion provides the answers to the meaning based questions that arise following a death. Religious coping adds the unique benefit of offering some of the answers to meaning based questions of the parentally bereaved child. Children as young as 8 years old search for meaning after the death of their parent. According to Pargament (1998) the distinct contributions provided by religion is as follows:

> Religion offers a response to the problems of human insufficiency. Try as we might to maximize significance through our own insights and experiences or through those of others, we remain human, finite, and limited. At any time we may be pushed beyond our immediate resources, exposing our basic vulnerability to ourselves and the world. To this most basic of existential crises, religion holds out solutions. The solutions may come in the form of spiritual support when other sources of social support are lacking, explanations when no other explanations seem convincing, a sense of ultimate control through the sacred when life seems out of control, or new objects of significance when old ones are no longer compelling. In any case, religion complements non-religious coping, with its

> emphasis on personal control, by offering responses to the limits of personal powers. Perhaps that is why the powers of the sacred become most compelling for many when human powers are put to their greatest test (pp.310).

Religion goes beyond complementing nonreligious coping methods to offer the church and its members as a support system. It offers an avenue of forgiveness and access to the sacred, a unique source of power and strength. It finally offers the unique contribution of providing answers to the questions that nonreligious coping methods don't address.

Despite the undisputed importance of parental support for a grieving child, many questions remain about what specific parent behaviors best facilitate the child's adaptation to loss (Tremblay & Israel, 1998).

Summary

Although researchers have been studying coping for some time, religion is a vastly understudied area in childhood bereavement (Herr, 1999). Psychologists have traditionally been reluctant to venture into this realm of investigation. Yet, questions about spirituality and meaning in life seem almost invariably woven into the bereavement experience (Tremblay & Israel, 1998). It is a pathway that many people choose in times of crisis, yet parental religious coping and child adjustment have thus far remained excluded from research. Research is beginning to provide evidence regarding the benefits of religious coping, but how do these benefits affect the children? This study begins to answer the question of how a parent's religious coping effect's the surviving child. The chapter that follows goes into greater detail by outlining the research methodology.

Hypotheses

Hypothesis 1: Time since the death, years known the deceased, parent's age, child's age, closeness of child to the dead and surviving parent, and positive religious coping will negatively correlate with externalization and internalization of symptoms post-loss.

1a: The group differences between other death context variables, such as child's gender, expected or unexpected death, and gender match will be examined for positive religious coping, negative religious coping, and externalization and internalization of symptoms post-loss.

Hypothesis 2: Positive religious coping (spiritual connection, seeking spiritual support, religious forgiveness, collaborative religious coping, benevolent religious reappraisal and religious purification) as used by the parent, will negatively correlate with externalization and internalization of symptoms of children post-loss.

2a: The group of RCOPE positive subscales that contribute most to the negative correlation between religious coping and externalizing symptoms will be explored.

2b: The group of RCOPE positive subscales that contribute most to the negative correlation between religious coping and internalizing symptoms will be explored.

Hypothesis 3: Negative religious coping (spiritual discontent, punishing God reappraisal, interpersonal religious discontent, demonic reappraisal and reappraisal of God's power) will positively correlate with externalization and internalization of symptoms post-loss.

3a: The group of RCOPE negative subscales that contribute most to the positive correlation between religious coping and externalizing symptoms will be explored.

3b: The group of RCOPE negative subscales that contribute most to the positive correlation between religious coping and internalizing symptoms will be explored.

Method

Participants

Fifteen bereaved parents with children in the appropriate age range self selected from bereavement groups, churches, hospices, and palliative care programs in the United States (10% overall response rate). Program coordinators and staff from bereavement groups, churches, hospices, and palliative care programs were contacted by phone and asked whether or not there were any bereaved spouses in their organization who met the criteria for participation. One hundred surveys were sent to those groups in the Southern California area who agreed to participate and who had participants who met the criteria for participation. Eleven completed surveys were returned (11% response rate). Additional groups were contacted in California for participation, but due to their poor response rate for additional participation and due to the initial poor return rate an additional 50 surveys were sent to churches willing to participate outside of California. Only 4 additional surveys (8% response rate) were returned. Of those 4 returned surveys one of the families had experienced the loss of the parent due to a heart attack he sustained as a result of his rescue efforts after the September 11 terrorist attacks.

Families who had children between the ages of 7 and 14 years who lost a parent in the past 3 years due to illness or accident were eligible to participate in the study. Parents lost through suicide or violent deaths, such as murder, were excluded from participation in the research project. The results of this study were based on parental reports of their children's behavior. If there was more than one child between the ages of 7 and 14 years in the family the parent was asked to complete information on only the oldest child in that age category. The children were never contacted.

Materials

A demographic data sheet and two questionnaires were used for this study. The demographic data sheet included questions on age, gender, death context, and education. The questionnaire included *The Brief Religious Coping Scale (Brief RCOPE)* and *Child Behavior Checklist (CBCL)*. Both were self-report measures chosen for their construct validity.

The *Brief Religious Coping Scale* is a 14-item measure of positive and negative patterns of religious coping (Pargament et al., 1996). Positive patterns of religious coping comprises of the following subscales: spiritual connection, seeking spiritual support, religious forgiveness, collaborative religious coping, benevolent religious reappraisal and religious purification. Negative patterns of religious coping include the following subscales: spiritual discontent, punishing God reappraisal, interpersonal religious discontent, demonic reappraisal and reappraisal of God's power. Individuals were asked to rate how much they used activities to cope on a 4-point Likert scale ranging from (0) not at all to (3) a great deal. A sample question from the positive religious coping subscale includes, "Looked for a stronger connection with God". A sample question from the negative religious coping subscale includes, "Felt punished by God for my lack of devotion". The internal consistency reliability for positive religious coping and negative religious coping are .90 and .81 respectively. Research has also shown convergent and discriminant validity for this measure (Pargament et al., 1996).

The *Child Behavior Checklist* is a 113-item parent rating that assesses behavioral problems and competencies for children ages 4 to 18 years old (Sajatovic & Ramirez, 2001). Items are rated on a 3-point scale (0) not true (1) somewhat or sometimes true (2)

very true or often true. The checklist comprises of 8 subscales: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent and aggressive behavior. The subscales are grouped into two broad groupings: internalizing and externalizing. Internalizing comprises the withdrawn, somatic complaints and depressed/anxious subscales and externalizing comprises the aggressive and delinquent behavior subscales. A sample question on the internalizing scale includes "Child doesn't get involved with others". A sample question on the externalizing scale includes "Argues a lot". Each subscale was examined as well as the broad internalizing and externalizing scales. Reliability of the composite behavioral problem scores is excellent, with internal consistency and one-week test-retest coefficients above .89 (Sajatovic & Ramirez, 2001).

Design and Procedure

A correlational design was used for this study. A correlational design was chosen due to its practicality and ability to measure the association between the independent and dependant variables. A limitation of a correlational design is the inability to observe change over time and the inability to assume a cause and effect relationship between the variables. However, due to the small sample and the exploratory nature of the research, a correlational design was deemed adequate.

Program coordinators and staff from bereavement groups, churches, hospices, and palliative care programs were contacted by phone and asked whether or not there were any bereaved spouses who met the participant criteria for participation in their organization. The church staff and program coordinators handed out the questionnaire packets to bereaved spouses. The surviving parent's received a packet including a letter

of introduction, informed consent letter, demographic data sheet and two questionnaires. The letter of introduction provided a description and explanation of the study (see Appendix A). An informed consent letter described the types of questions they would be asked, potential risks and benefits of participation, that data would be anonymous, and a contact phone number (see Appendix B). The demographic data sheet and questionnaires described in the measures section can be referred to in appendices C and D. The questionnaire packet was sent by mail to the bereavement groups, churches, hospices, palliative care programs and included a pre-paid stamped envelope for returning the questionnaires.

Participants included families who lost a parent due to death in the past 4 to 38 months. They were given a local phone number to address any questions about the project and two referral sources if needed.

Results

Sample Demographics and Missing Data Treatment

The sample consisted of fifteen children: 60% were male and 40% were female. The majority of the surviving parents were mothers (87%), with the remainder of the surviving parents being fathers (13%). The majority of the families were Protestant (47%) and Caucasian (74%). Most of the deaths' were unexpected (58%) and the time since death ranged from 4 to 38 months (M = 18.73, SD = 10.76). Children's ages ranged from 7 to 14 years (M = 10.87, SD = 2.13) and surviving parent's ages ranged from 30 to 55 years (M = 43.93, SD = 6.45). The surviving parent's level of education ranged from High School degree to Graduate degree. Missing items were deleted from the sample. See Table 1 for detailed sample demographics.

Table 1

Sample Demographics

Child's Gender	Female	40% (6)
	Male	60% (9)
Surviving Parent's Gender	Mothers	87% (13)
	Fathers	13% (2)
Religion	Protestant	47% (7)
	Catholic	40% (6)
	Other	13% (2)
Ethnicity	Caucasian	74% (11)
	Hispanic	13% (2)
	African American	13% (2)
Death Circumstances	Expected	42% (5)
	Unexpected	58% (7)
	Missing	3% (3)
Education	High School	20% (3)
	Technical School	33% (5)
	Junior College	20% (3)
	Graduate School	27% (4)

Intracorrelations within Death Context Variables

Before examining correlation coefficients, all scale scores were screened for normality, outliers, skew, and kurtosis (see Figures 1 to 5 in Appendix E). All variables demonstrated a normal distribution with no outliers. Therefore, correlational analyses were conducted on all subjects and all continuous variables in the following sections.

Due to the low power of the study sample, correlations were examined at the $p <$ .07, .05 and .01 significance levels. An examination of the death context correlations in Table 2 indicates that the parent's age positively correlates with years the parent knew the deceased spouse. All other correlations were positive though non-significant. Due to the restriction of range for closeness of the child to the dead and surviving parent, (all participants rated this as 9 or 10 on a 10 point scale) these two variables were not examined further.

Table 2

Death Context Variables

	Months Since Death	Years Known Deceased	Child's Age	Parent's Age
Months Since Death	1.0			
Years Known Deceased	-.08	1.0		
Child's Age	.28	.27	1.0	
Parent's Age	.30	.53**	.05	1.0

*$p < .07$ **$p < .05$ ***$p < .01$

Intracorrelations within Religious Coping Variables

Examinations of the religious coping variables in Table 3 reveal similar correlations as predicted by the research literature, indicating that though the sample is small, the scales are operating as expected. Positive religious coping positively correlates with spiritual connection, seeking spiritual support, religious forgiveness, collaborative religious coping, benevolent religious reappraisal and religious purification. Positive religious coping negatively correlates with spiritual discontent, punishing God reappraisal, interpersonal religious discontent and reappraisal of God's power. Positive religious coping negatively correlates with demonic reappraisal, though this finding was nonsignificant.

Negative religious coping positively correlates with spiritual discontent, punishing God reappraisal, and reappraisal of God's power. Negative religious coping positively correlates with interpersonal religious discontent and demonic reappraisal, though this finding was nonsignificant. Finally, negative religious coping negatively correlates with spiritual connection, seeking spiritual support, collaborative religious coping, and benevolent religious reappraisal. Negative religious coping negatively correlates with religious forgiveness, though this finding was nonsignificant. The internal consistency reliability for positive religious coping and negative religious coping in the present sample are .82 and .91, respectively. These alphas are similar to those reported by Pargament et al., (1996).

Table 3

Religious Coping Variables

	Positive Religious Coping	Negative Religious Coping
Spiritual Connection	.89***	-.58**
Seeking Spiritual Support	.85***	-.67***
Religious Forgiveness	.63**	-.46
Collaborative Religious Coping	.83***	-.62**
Benevolent Reappraisal	.74***	-.68***
Religious Purification	.73***	-.22
Spiritual Discontent	-.77***	.95***
Punishing God Reappraisal	-.60**	.97***
Interpersonal Religious Discontent	-.68***	.50*
Demonic Reappraisal	-.03	.48
Reappraisal of God's Power	-.60**	.97***

*$p < .07$ **$p < .05$ ***$p < .01$

Intracorrelations within Child Adjustment Variables

An examination of the child adjustment variables reveals similar correlations to those predicted by the research literature again indicating that though the sample is small, the scales are operating as expected. Children's internalizing symptoms positively correlate with withdrawn and anxious-depressed symptoms as well as somatic complaints. Externalizing symptoms likewise positively correlate with somatic

complaints as well as social problems, attention problems, delinquent and aggressive behaviors.

Table 4

Child Adjustment Variables

	Internalizing Symptoms	Externalizing Symptoms
Withdrawn	.73***	.36
Somatic Complaints	.54**	.54**
Anxious Depressed	.76***	.20
Social Problems	.44	.72***
Attention Problems	-.13	.67***
Thought Problems	.13	.04
Delinquent Behavior	.30	.72***
Aggressive Behavior	.25	.85***

*$p < .07$ **$p < .05$ ***$p < .01$

Intercorrelations between Death Context and Religious Coping Variables

The death context variables were unrelated to religious coping styles (see Table 5). However, several correlations seem strong and may become significant in larger samples. For example, years known the deceased and parent's age may be negatively correlated with positive religious coping with more power.

Table 5

Death Context and Religious Coping Variables

	Positive Religious Coping	Negative Religious Coping
Months Since Death	-.13	-.03
Years Known Deceased	-.35	-.06
Child's Age	.09	-.11
Parent's Age	-.31	-.09

$^{*}p < .07$ $^{**}p < .05$ $^{***}p < .01$

Intercorrelations between Death Context and Child Adjustment Variables

Hypothesis 1 stated that time since the death, years known the deceased, parent's age, child's age, closeness of child to the dead and surviving parent, and positive religious coping would negatively correlate with externalization and internalization of symptoms post-loss. The findings did not confirm the hypothesis. The death context variables were unrelated to child adjustment variables (see Table 6). Although these variables were unrelated to the two broad groupings of internalizing and externalizing of symptoms, the following death context variables negatively correlate with several specific internalizing and externalizing subscales. Child's gender significantly correlates with attention problems ($r = -.57, p < .05$) and the gender match between the child and deceased parent significantly correlates with aggressive behaviors ($r = -.63, p < .05$). A trend can be seen in the negative correlation between the gender match of the child and deceased parent and somatic complaints ($r = -.47, p < .07$). A trend can be seen in the negative correlation between child's age and anxious/depressed symptoms ($r = -.50, p < .07$), as well as months since parental death and thought problems ($r = -.48, p < .07$).

Table 6

Death Context and Child Adjustment Variables

	Internalizing Symptoms	Externalizing Symptoms
Months Since Death	.05	-.04
Years Known Deceased	-.01	-.36
Child's Age	-.40	.06
Parent's Age	.13	.31

$^{*}p < .07$ $^{**}p < .05$ $^{***}p < .01$

Group Differences

Hypothesis 1a stated that the group differences between other death context variables, such as child's gender, expected or unexpected death, and gender match would be examined for positive religious coping, negative religious coping, and externalization and internalization of symptoms post-loss. The death context groups of gender match, death expectation, and child's gender, were compared on religious coping and child adjustment with ANOVA's (see Table 7). The analyses confirmed the hypothesis that the gender match group demonstrated significantly more externalizing symptoms than the gender nonmatch group $F(1, 15) = 10.22, p = .007$. A trend can be seen in children who experienced an unexpected death who demonstrated significantly more externalizing symptoms than the children who experienced an expected death $F(1, 15) = 4.23, p = .067$.

Table 7

Group Differences

	Internalizing Symptoms	Externalizing Symptoms	Positive Religious Coping	Negative Religious Coping
Child's Gender				
Male	48.66 (10.18)	50.11 (10.69)	20.22 (6.55)	9.11 (4.88)
Female	46.83 (7.90)	44.83 (5.70)	19.00 (3.68)	7.66 (1.21)
Expected Death	48.80 (4.92)	42.6 (5.59)	19.60 (5.68)	7.8 (1.30)
Unexpected Death	48.28 (12.88)	52.28 (9.32)*	20.14 (5.75)	9.42 (5.59)
Deceased Parent				
Gender Match	52.14 (8.05)	54.28 (9.01)***	17.71 (6.94)	10.00 (5.41)
Non-match	44.25 (8.73)	42.5 (4.95)	21.50 (3.25)	7.25 (0.46)

$^{*}p < .07$ $^{**}p < .05$ $^{***}p < .01$

Intercorrelations between Religious Coping and Child Adjustment Variables

Hypothesis 2 stated that positive religious coping (spiritual connection, seeking spiritual support, religious forgiveness, collaborative religious coping, benevolent religious reappraisal and religious purification) as used by the parent, would negatively correlate with externalization and internalization of symptoms of children post-loss. The findings confirm the hypothesis that the surviving parent's positive religious coping negatively correlates with externalization of symptoms of children post-loss (Table 8). The findings did not confirm the hypothesis that the surviving parent's positive religious

coping negatively correlates with internalization of symptoms of children post-loss (Table 8).

Hypothesis 2a stated that the group of RCOPE positive subscales that contribute most to the negative correlation between religious coping and externalizing symptoms would be explored. The six subscales that constitute positive religious coping included: spiritual connection, seeking spiritual support, collaborative religious coping, benevolent religious reappraisal, religious forgiveness and religious purification. Correlations were calculated to determine which subscales most contributed to the negative correlation of externalization of symptoms. Spiritual connection and seeking spiritual support was the group of positive religious coping scales used by the parent that most contributed to the negative correlation of externalization of symptoms in children.

Hypothesis 2b stated that the group of RCOPE positive subscales that contribute most to the negative correlation between religious coping and internalizing symptoms will be explored. Because the hypotheses regarding the negative correlations between positive religious coping and internalization of symptoms was not confirmed, the subscale correlations of positive religious coping with internalization of symptoms were not examined.

Hypothesis 3 stated that negative religious coping (spiritual discontent, punishing God reappraisal, interpersonal religious discontent, demonic reappraisal and reappraisal of God's power) would positively correlate with externalization and internalization of symptoms post-loss. The findings confirmed the hypothesis that parental negative religious coping positively correlates with externalization of symptoms of children post-loss (Table 8). The findings did not confirm the hypothesis that parental negative

religious coping positively correlates with internalization of symptoms of children post-loss (Table 8).

Hypothesis 3a stated that the group of RCOPE negative subscales that contribute most to the positive correlation between religious coping and externalizing symptoms would be explored. The five subscales that constitute negative religious coping included: spiritual discontent, interpersonal religious discontent, punishing God reappraisal, demonic reappraisal, and reappraisal of God's power. Correlations were calculated to determine which subscales contributed to the positive correlation of negative religious coping and externalization of symptoms. All subscales contributed to the positive correlation of externalization of symptoms and therefore the hypothesis is supported.

Hypothesis 3b stated that the group of RCOPE negative subscales that contribute most to the positive correlation between religious coping and internalizing symptoms would be explored. Because the hypotheses regarding the negative correlations between parental negative religious coping and internalization of symptoms was not confirmed, the subscale correlations of negative religious coping with internalization of symptoms were not examined.

Table 8

Religious Coping and Child Adjustment Variables

	Internalizing Symptoms	Externalizing Symptoms
Positive Religious Coping	-.03	-.55**
Negative Religious Coping	.21	.69***

*$p < .07$ **$p < .05$ ***$p < .01$

Qualitative Examination of Religious Coping and Child Adjustment Scores

Several themes emerged from the qualitative examination of the parent's use of religious coping and child adjustment post-loss. Religious coping provided access to the sacred, a unique source of power and strength. In the open ended comment section of the questionnaire the surviving parents reported using positive religious coping strategies including a spiritual connection to God, seeking spiritual support from God, and a collaboration with God. Specifically, one surviving parent looked for a stronger connection with God by "immersing themselves in prayer, through meditation, filling their mind with spiritual things, and heavenly thoughts". The parents also reported seeking spiritual support from God by seeking His love and care, attempting to draw near to God, receiving comfort from God and strength from God. Several parents sought a collaboration with God by trying to put their future plans into actions together with God. One parent specifically wrote, "I try to be true to God's wishes and try to follow my heavenly father's will in my life. I know the Lord is with me and my children and will guide and direct us through this life until our purposes on earth have been accomplished".

First, positive religious coping also provided for a problem and emotion-focused way of coping by providing answers that can help facilitate cognitive restructuring of the many questions and painful feelings that remain after a death. There are often many questions asked after the death of a loved one. Children will likewise have questions about why their parent has died and they will look to the surviving parent for guidance on what to believe about the causes of the death. The parent's reported looking at their own beliefs about death and dealing with the loss and were able to pass on that information to their children. In doing so, the parent's felt they were able to effectively deal with the

questions posed to them by their children. One parent wrote that "they were believing that God might heal the dad, if it were within His will and plans for him". She further wrote that she would one day be reunited with her husband in heaven and that "my son loves his daddy and knows he will see him again in heaven". The parent already had an established orienting system that included the belief that humans live a purposeful existence and could answer questions such as, the nature of what happens when a person dies, and was able to transmit this to her son. The parents who expressed these beliefs and connections with God also reported externalizing and internalizing symptoms for their children well within normal limits on the CBCL.

Second, an examination of the qualitative data revealed that the closeness of the pre-existing relationship to the deceased and surviving parent is a factor that plays a mediating role in a surviving parent's and child's grieving process. It is the nature of the pre-existing relationship with the deceased and the nature of the relationship with the surviving parent that is of key importance, more so than the unexpected or expected nature of the death, though this was not specifically revealed in the quantitative data. Just as is true of adults, a relationship that is marked by difficulties when the parent is alive, will likely result in continued difficulties when the parent dies. One parent wrote, "I thank God that the day my husband died unexpectedly I didn't regret anything about that day except the death itself. Each child and myself left him in a good way with no regrets".

Third, the surviving parent must now adapt to their new role as a single parent. Roles that were once filled by the deceased parent needed to be filled by the surviving parent or be left vacant. How the various roles once performed by the deceased are

fulfilled, reshaped, or left vacant is a question that the parents reported struggling with. Not only does the surviving parent have to adapt to a new economic status, shouldering more of the caretaking and disciplinary responsibilities, but they reported being faced with the loss of the "father or mother figure" that the other parent provided. The child must also cope with the loss of the figure who provided this necessary relationship in a secure environment, a role that the surviving parent reported only the deceased parent could fulfill. Several parents wrote about the loss of the role model that the other parent had provided to the child. One parent specifically wrote about the concern over the loss of the male or father figure for the child. Another parent wrote, "I would like him to have a good male role model". While another wrote, "My child would really like a father figure in his life, to do the manly things like sports".

Discussion

Though the sample of bereaved families in this study is small, a number of patterns emerge to indicate that this is an important area of research. First, the results of this study support the hypotheses that parents who use positive religious coping strategies report less externalizing symptoms while those who use negative religious coping strategies report more externalizing symptoms in their children after the death of their spouse. Second, the results do not support the hypotheses that parents who use positive religious coping strategies report less internalization of symptoms in their children. Nor do the results of the study support the hypothesis that parents who utilize a negative religious coping style will report an increase in internalization of symptoms in their children.

The present findings are consistent with the theoretical and empirical work that indicates positive religious coping may provide a multitude of benefits such as comfort, personal growth stimulation, a sense of intimacy with God, closeness with others, or meaning and purpose in life (Pargament & Park, 1995). Positive religious coping, for example, is linked to greater overall mental health and positive well-being for ill patients as well as stress-related growth following traumatic events. This study explored the benefits that religious coping provided to the grieving parent thereby helping to promote an environment for the healthy adjustment of children following the loss of a parent. The results are also consistent with past research that indicates negative religious coping may be harmful to post loss adjustment (Pargament, 1997). In this study, the parent's negative religious beliefs and coping strategies related to more externalization of symptoms in the surviving child. The finding concerning more externalizing symptoms may relate to the

high rate of male children who were rated by their parents for this study since males demonstrate more externalizing than internalizing symptoms overall.

An evaluation of the death context variables is also important in understanding the impact of parental loss on the child. Several death context and individual child variables impacted the child's grieving process post-loss. The gender match between the child and deceased parent significantly predicted more externalizing behaviors, specifically aggressive behaviors. In addition, it is possible that children who experienced an unexpected death demonstrated more externalizing symptoms than the children who experienced an expected death. Finally, male children may exhibit more thought problems following the loss. These results correspond with results found in larger studies. A child may show more emotional and behavioral problems following the death of a mother while preteen boys exhibit more behavioral problems after the loss of a father (Worden, 1996). Children in this age category were found to experience more social problems, cry more frequently, and to have more health problems following the death of a parent than children in other age groups. In addition, bereaved boys exhibit more aggressive and acting-out behaviors (Dowdney, 2000; Kaffman & Elizur, 1996).

Although the death context variables have an impact on the experience of the loss and the child's adaptation to the death of a parent, they alone do not predict the course of bereavement for the child. In light of the death context variables, and individual child characteristics, the differential impact of positive and negative religious coping strategies on children's symptoms emphasize the importance of the surviving parent's style of coping after the loss. A positive religious coping style is marked by feelings of support and access to resources that help answer the many meaning questions that arise after loss.

It provides a belief system that lends support, access to resources, answers to questions, and provides comfort in a time of loss. These factors are shown to provide stability for the family faced with the unstable and unsure environment after the loss a parent. Parents who have this belief system report their children to show less aggressive and delinquent behaviors after the death. Families employing negative religious coping do not have access to these coping strategies or resources. In addition, the use of a negative religious coping style by the parent is marked by anger, guilt, and blaming behaviors. These behaviors facilitate an unstable and unsupportive environment for the child. These parents also report that these types of aggressive and angry behaviors (e.g. externalizing symptoms) are exhibited by their children post-loss.

The results in this study correspond with recent theory on the importance of the surviving parent's coping style on the bereaved children. In the Longitudinal Child Bereavement Study those families who's children exhibited less difficulties following the death of their parent were families who, although they experienced the stress of the death, report that they were not necessarily depressed and rated their coping styles as good (Worden, 1996). Their coping strategies often involved a redefinition of what life would be like without the deceased parent, showed an absence of passivity, and some parents also reported that they found a new source of support and derived comfort from their religious beliefs.

These findings have numerous research and clinical implications. Traditionally, a person's religious or spiritual beliefs were an aspect rarely entered into in research and clinical practice. The field is changing and these aspects of human behavior are being studied. It is important for the clinician to ask about, acknowledge, and investigate the

impact of religious coping in the client's life. As has been shown the positive aspects of religious coping can aid in the coping process after the death of a parent. It is incumbent upon the clinician to address each aspect the client may be using to help them navigate the difficult process of loss, thereby helping the children likewise navigate the loss of their parent.

Study Limitations

The lack of findings that positive religious coping leads to less internalization of symptoms, while negative religious coping leads to more internalization of symptoms may be due to the methodological shortcomings of this study, including small sample size and convenience samples. The lack of support for these hypotheses may also be related to the more prevalent externalization of symptoms in children in this age group. It may also be that externalizing symptoms are the more obvious symptoms, such as aggressive behaviors, that need the immediate and corrective attention of the parent. Whereas, internalizing symptoms, such as withdrawal, are not as immediately evident to the parent and therefore not a focal point for a parent who is trying to cope with their own distress and sadness post-loss.

Finally, the above findings are similar to those predicted by the research literature again indicating that though the sample is small, the findings correspond with studies having more power.

Future Research

The primary limitation of this study was the sample size. The small sample size limits statistical power. Ideally, future studies should include a larger sample size. Future investigations should employ different recruitment tools that are more personal,

such as using an interview format to gather data and having personal contact with the bereaved families, to request their participation in the study. To maintain privacy and anonymity, the researchers were forced to end their contact at the level of the administrators of churches and bereavement groups. This was not an adequate approach to enroll subjects into the study and other methods should be explored to further the work in this research area.

The correlational design is also a limitation, because is does not allow one to determine whether the symptoms reported are a direct result of the bereavement, parental coping, or if those symptoms were present before the death of the parent. It also does not allow one to evaluate potential changes in the child's adjustment over time. A longitudinal study would be preferable, because it would allow one to follow changes in adjustment over time. For example, an initial use of negative religious coping may exacerbate the child's symptoms, however, a parent may begin to adjust and employ more positive strategies over time. This could in turn impact the child's long term adjustment positively.

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Appendix A

Letter of Introduction

April 10, 2002

Redlands Seventh-day Adventist Church
520 Brookside Avenue
Redlands, CA 92373
909.793.6337 phone
909.793.8257 fax

Dear Pastoral Staff:

We are requesting your help in contacting individuals to participate in a research study. Our research is designed to gain a better understanding of the role of religiosity in coping with grief and symptoms exhibited by children following the loss of a spouse.

The role of religious coping has been understudied in the past. Researchers left religiosity to religious groups and omitted looking at its role in influencing an individual's life even when the majority of the population indicates religion to be a major factor influencing their lives. Some of the questions on religious coping after a loss of a spouse are very personal and some may be painful to answer. But if we are to provide good care for our clients and their families during this difficult phase of life, we need to know more about these issues. Specifically, we are looking for individuals who have children between the ages of 8 to 12, who have lost a spouse, by accident or illness, within the past 2 years.

I hope we can contact any church members that meet this criteria, to ask them to complete a brief survey and return it to the research team at Loma Linda University. We feel that individuals are safe in participating in this study because we have taken several steps to safeguard their privacy.

First of all, they are under no obligation to participate. If at any point while filling out the questionnaire they decide they no longer wish to participate, they may stop where ever they are and fill out no more. If there are any particular questions that they want to skip, they may do so. We only ask that they return their survey to us in whatever degree of completion they decide is best for them. Secondly, all surveys are anonymous. The information they provide will be added with information from other participants.

They would need to take about 45 minutes to one hour to complete the survey, insert it into the self-addressed and stamped envelope that we will provide, and mail it to us. If they do not wish to be contacted further, they simply have to check the "decline to

participate" box and mail back the blank survey. We will respect their wishes and will contact them no further.

If you have any questions about this project, please do not hesitate to contact Dr. Kelly R. Morton at (909) 558-8165.

Thank you in advance for your time and cooperation in reading this brief introduction of this important project. We hope you would consider helping us find individuals that meet the criteria for our study. This study will help bring religiosity into the field of research done by social scientists and will provide a better understanding of religious coping for individuals experiencing grief.

We will be contacting you with a follow up phone call in the next few days. Please feel free to contact us if you have any questions at (909) 558-8165.

Sincerely,

____

Beatrice Tauber, MA, NCC
Doctoral Student

____

Kelly R. Morton, Ph.D.
Associate Professor
Departments of Family Medicine & Psychology

Appendix B

Informed Consent Letter

April, 2, 2002

Dear Participant,

You are invited to participate in a research survey that will explore the role of religiosity in families coping with the loss of a spouse/parent.

Coping with the loss of a spouse or a parent has been understudied. Researchers have left religiosity to religious groups, and have not examined the grief of children to a great degree. We realize this is a very difficult time for you and for your family. Some of our questions are very personal and some may even be painful for you to answer. As psychologists, we want to learn to provide the best treatment possible to families during difficult times. To do this, we need to know more about grief issues from people like you.

We hope that with this in mind, and the knowledge that everything you answer here is anonymous, that you will decide to complete this survey and return it to us at Loma Linda University. We feel that you are safe in participating in this study because we have taken several steps to safeguard your privacy.

First of all, you are under no obligation to participate. If at any point while filling out the survey you decide you no longer wish to participate, you may stop wherever you are and fill out no more. The questions concern religiousness, coping, grief and the adjustment of one of your children between the ages of 8 to 12 post-loss. If there are any particular questions that you want to skip, you may do so. We only ask that you return your survey to us in whatever degree of completion you decide is best for you. Secondly, all surveys are anonymous. The information you provide will be added with information other participants provide to help us learn more about families who has experienced the death of a loved one.

Please take 45 minutes to one hour right now to complete this survey, insert it into the self-addressed and stamped envelope that we have provided, and mail it to us. By returning the survey, you will be consenting to have your responses included in our studies. If you do not wish to be contacted further, simply check the "decline to participate" box and mail back the blank survey. We will respect your wishes and will contact you no further.

If you have any questions about this project, please do not hesitate to contact Dr. Kelly R. Morton at (909) 558-8165. You may also contact a patient representative who is an impartial third party not involved with this study at (909) 558-4567.

Thank you in advance for your time and cooperation in this important project.

If you feel that you would like to talk with someone about the feelings you have experienced after the loss of your loved one, we would like to suggest the following sources who may be able to help you:

Loma Linda University Medical Center
Grief Recovery Groups
(909) 824-4367

Loma Linda University Psychological Services
Department of Psychology
(909) 558-8576

Sincerely,

____
Beatrice Tauber, MA, NCC
Doctoral Student

____
Kelly R. Morton, Ph.D.
Associate Professor
Departments of Family Medicine & Psychology

Appendix C

Demographic Data Sheet

COPING WITH GRIEF

☐ I decline to participate in this project (Please, return your blank survey in the enclosed envelope).

If you choose to participate, please answer the following questions about yourself, your child and your deceased spouse

The following questions are about yourself:

What is your gender?

☐ Male ☐ Female

What is your age?_______________

What is your ethnicity/race?

☐ White/Caucasian ☐ Black/African American ☐ Latino/Hispanic

☐ Asian American/Pacific Islander ☐ Other_______________

What is your approximate gross annual income?

☐Less than $10,000 ☐$10,000-$25,000 ☐$25,001-$50,000

☐$50,001-$75,000 ☐Greater than $75,001

What is your religious affiliation

☐ Protestant ☐ Catholic ☐ Jewish ☐ Other _______________

What is your highest level of education?

☐ Elementary ☐ High School ☐ Junior College ☐ Technical School

☐ University ☐ Graduate School

The following questions are about the deceased:

What was the cause of death?____

What was the date of death?____

Was the death:

☐ Expected ☐ Unexpected

What was the deceased's gender?

☐ Male ☐ Female

What was the deceased's ethnic background?
☐ White/Caucasian ☐ Black/African American ☐ Latino/Hispanic
☐ Asian American/Pacific Islander ☐ Other_______________

What was the deceased's religious affiliation
☐ Protestant ☐ Catholic ☐ Jewish ☐ Other _______________

What was the deceased's highest level of education?
☐ Elementary ☐ High School ☐ Junior College ☐ Technical School
☐ University ☐ Graduate School

How long did you know the deceased?
__________years __________months

How close did you feel to him/her most of the time?
Not Much A Little Extremely Close

1	2	3	4	5	6	7	8	9	10

The following questions are about your child (if you have more than one child between the age of 8 to 12 years, please choose your oldest for whom you will complete this survey):

What is your child's age?_____________

What is your child's gender?
☐ Male ☐ Female

How close did your child feel to the deceased most of the time?
Not Much A Little Extremely Close

1	2	3	4	5	6	7	8	9	10

How close does your child feel towards you most of the time?
Not Much A Little Extremely Close

1	2	3	4	5	6	7	8	9	10

Are you or any of your children in bereavement counseling or treatment?

____

Appendix D

Brief Religious Coping Scale

The following items deal with ways you coped with the death of your spouse. There are many ways to try to deal with the death of a spouse. These items ask what you did to cope with your loss. Obviously different people deal with things in different ways, but we are interested in how you tried to deal with it. Each item says something different about a particular way of coping. We want to know to what extent you did what the item says. Don't answer on the basis of what worked or not – just whether or not you did it. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1. Looked for a stronger connection with God.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

2. Sought God's love and care.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

3. Sought help from God in letting go of my anger.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

4. Tried to put my plans into action together with God.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

5. Tried to see how God might be trying to strengthen me in this situation.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

6. Asked forgiveness for my sins.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

7. Focused on religion to stop worrying about my problems.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

8. Wondered whether God had abandoned me.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

9. Felt punished by God for my lack of devotion.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

10. Wondered what I did for God to punish me.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

11. Questioned God's love for me.
☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

12. Wondered whether my church had abandoned me.

☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

13. Decided the devil made this happen.

☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

14. Questioned the power of God.

☐ *Not at all* ☐ *Somewhat* ☐ *Quite a bit* ☐ *A great deal.*

Appendix E

Histograms to Assess Normality

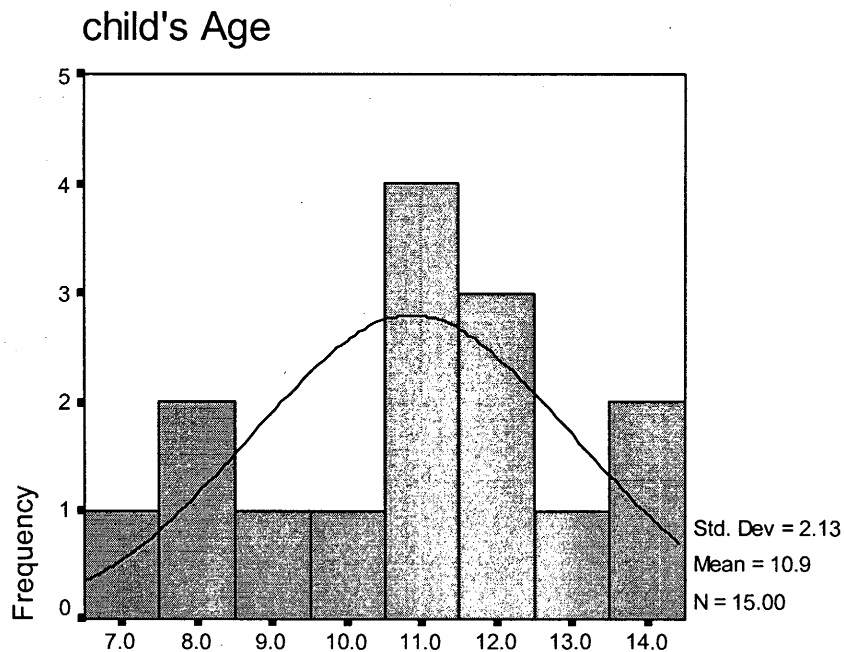

Figure 1. Normal range in age of child participants.

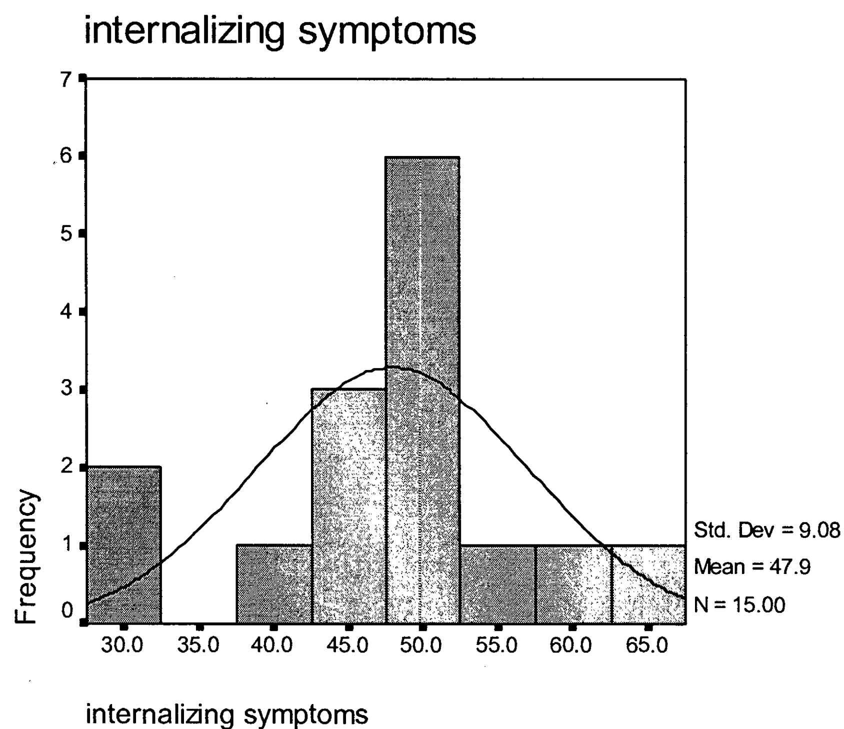

Figure 2. Normal range in internalizing symptoms exhibited by children post-loss.

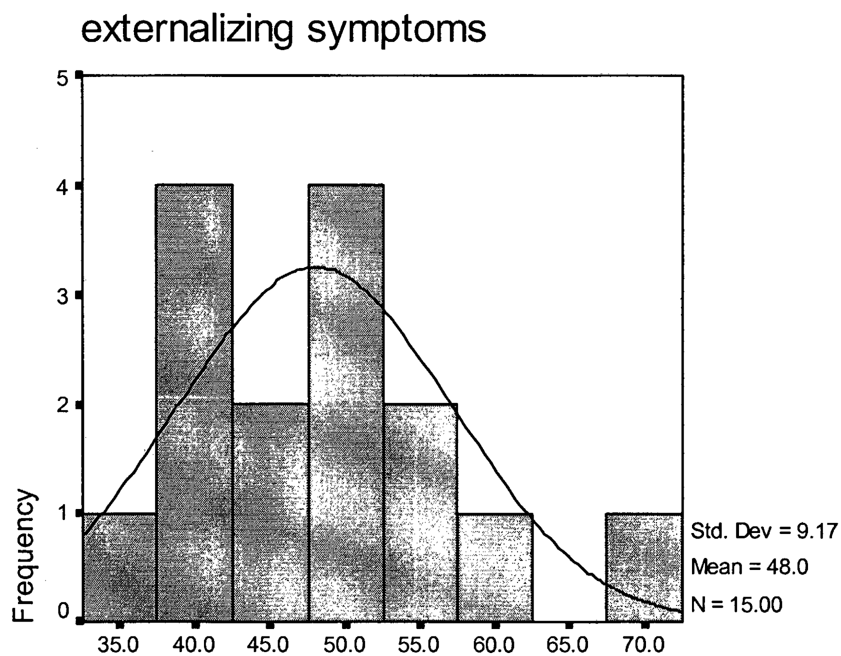

Figure 3. Normal range in externalizing symptoms in children post-loss.

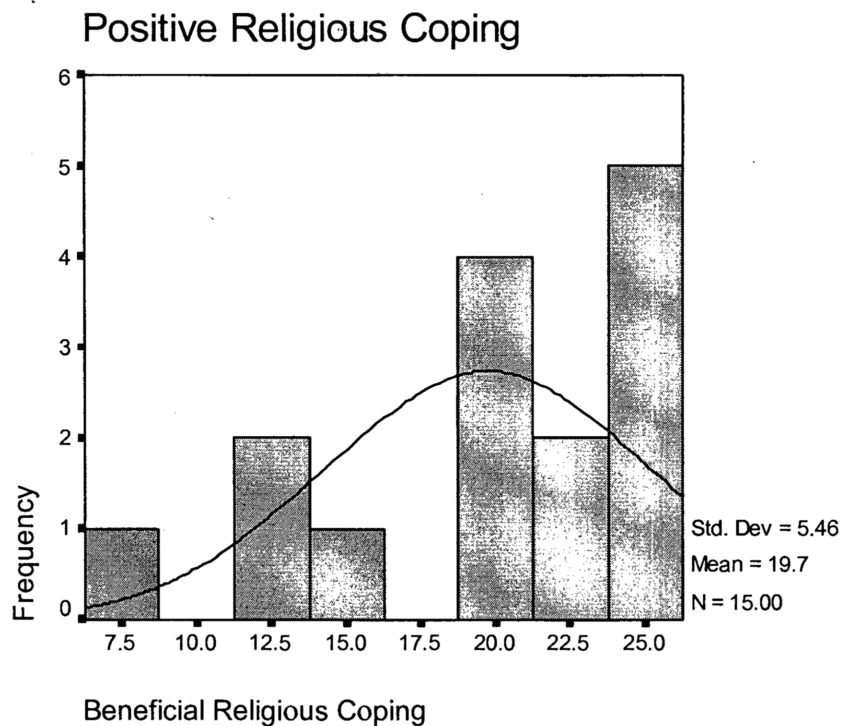

Figure 4. Normal range in the use of positive religious coping by parent's post-loss.

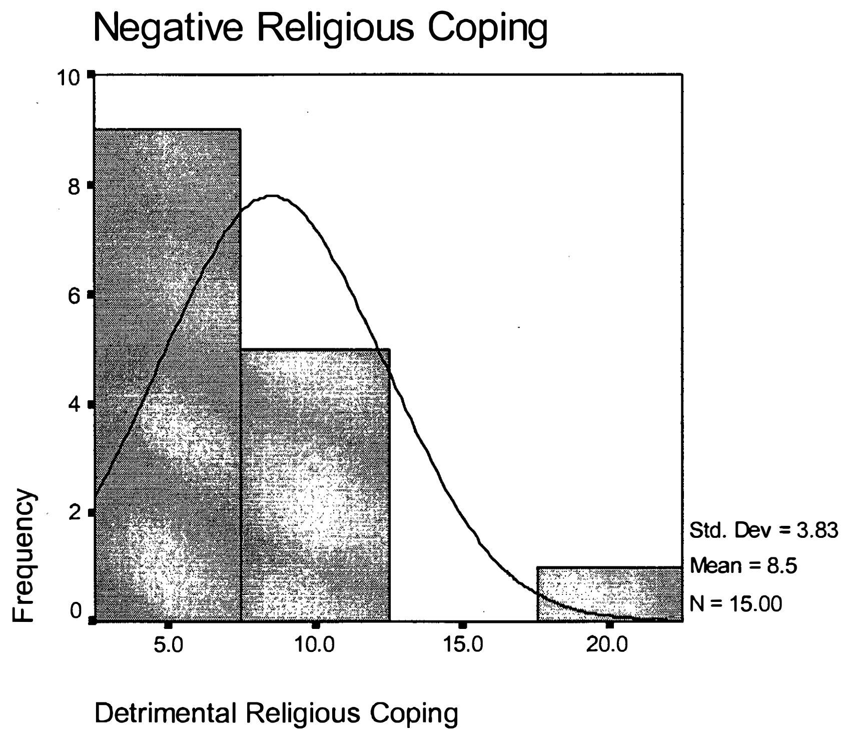

Figure 5. Normal range in negative religious coping used by parent's post-loss.