RELIGIOUS COPING IN TRAUMATIC BEREAVEMENT

By

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Abstract:

Traumatic bereavement as the result of homicide, suicide, or accident has been shown to be a risk factor for Complicated Grief (CG). Religious belief is often cited as a source of comfort during times of loss. This study examined whether traumatically bereaved individuals were more likely to engage in positive or negative religious coping, and whether religious coping style was associated with the severity of grief symptoms. To assess these questions, 42 traumatically and non-traumatically bereaved individuals completed the ICG and the RCOPE. It was found that the traumatically bereaved were significantly more likely to utilize positive religious coping strategies than negative religious coping strategies. However, when either group utilized negative religious coping strategies, this was strongly correlated with higher measures of grief severity.
**Religious Coping in Traumatic Bereavement**

According to the Center for Complicated Grief out of Columbia University, an estimated 10 million Americans might suffer from complicated grief (CG). Even considering the known heterogeneity of grief responses, this statistic represents a massive public health concern beyond that posed by depression and post-traumatic stress disorder (PTSD) alone (Bonanno 2007). It is well noted in the bereavement literature that a significant minority of individuals suffering the loss of a loved one develop CG. One instructive study which surveyed 2,500 bereaved adults found that %13 fell into a chronic grief state (Maccullum 2015). When considering the suffering of this sizeable minority, the necessity of research underlying the factors that may exacerbate or ameliorate the severity of the grief state becomes clear. The fact that bereavement is an often traumatic experience that nearly every person is likely to undergo at some point in their lifetime underlines this point. That is to say, nearly everyone is at risk of either encountering CG in a loved one or experiencing it themselves. Therefore, the research around these topics presents an opportunity to further understand the grieving psyche and to shed light onto the practical import of properly assisting these individuals.

Since it is now been sufficiently demonstrated that complicated grief presents a distinct diagnosis with its admittance to the DSM V, there is a sense of agreement on the markers by which it is identified. CG refers to prolonged impairment of social, emotional, and physiological function that can be persistent in many instances of bereavement, as a result of the loss (Shear 2012). It’s symptomology includes (but is not limited to) sleep disturbance, social withdrawal, intrusive thoughts, increased substance use, and suicidal ideation (Shear 2011). There is some debate in the literature as to when the normal grieving process ends and CG begins, though six
months post loss is a common metric. Although several crossover symptoms are present when comparing CG and similar disorders such as Major Depressive Disorder (MDD), a prolonged grief state nevertheless presents distinctively (Prigerson 1995). Longing for the deceased and ruminating over the loss, for instance, both feature prominently in CG whereas these cognitions are absent in MDD alone. There is evidence however, that CG can exacerbate preexisting pathology (Maccullum 2015). CG therefore, can be identified by looking for the symptoms which don’t overlap. This contrast is generally accomplished by consulting the DSM V and several diagnostic instruments along the same lines, including (and perhaps most prominently) the Inventory of Complicated Grief (ICG). Criteria broadly indicate CG in cases where both persistence and severity of the grief state are greater than expected (6 months +) as with respect to the standards offered in the ICG (Shear 2011).

Perhaps among the most obvious of risk factors contributing to the likelihood of CG is the suddenness or violence of the associated bereavement experience. As is the case with depression, there is evidence that CG is a separate condition from PTSD although again, some symptoms overlap. Notably, clear cases of CG often fall below the threshold for clinical relevance on PTSD inventories (Shear 2011). This makes sense when taking into account the differences between grief and trauma. Not all grief is traumatic and not all trauma requires the bereavement of a loved one. Still, some instances of grief are no doubt traumatic. Thus, since there is still some question in how to tease these two conditions apart, which has led some commentators to propose the category “traumatic grief”. These cases of traumatic or unexpected bereavement can often induce a severe grief state, especially when the loss was a result of accident, homicide, or suicide (Murphy 2003). Since this conception of traumatic grief
features prominently in literature already, it is how we will distinguish traumatic loss (bereavement resulting from accident, homicide, or suicide) from other forms of loss in the present analysis. Although work looking at how traumatic bereavement differs from other types of grief is in its infancy, there is a growing body of evidence examining traumatic grief as a distinct subset of CG. (Kaltman 2003). This study aims to add to this knowledge by further characterizing this portion of the CG population. As this research gains momentum, there is accumulating evidence that traumatic grief resulting from cases where bereavement is sudden, unexpected, or violent, may comprise a threat to mental health greater than that of CG in other cases (Prigerson 1997). Perhaps most importantly – that indicates that on a practical level, such cases may present a clinical challenge above and beyond the grief experienced due to a natural death (Barle 2015). This brings to mind a natural question for anyone interested in the maintenance of psychological well-being in the wake of such experiences: What strategies are most effective in coping with traumatic grief?

One natural way to begin formulating hypotheses to this effect is asking a descriptive question. How do people actually cope when confronted with a traumatic loss? In other words, when participants are asked to report on their coping, what commonalities are present in their answers and are those constructs in fact correlated with improved outcomes? Often, in instances of traumatic bereavement, religious belief and ritual are commonly cited sources from which individuals derive consolation. In Wortman et al.’s 2008 review, the authors observe, “With religion/spirituality so commonly invoked in response to bereavement, it is widely assumed to be helpful in this context. The bereaved likely turn to religion/spirituality in the face of loss seeking the comfort, coping resources, and meaning framework religion can
One challenge inherent to investigating religious coping is operationalizing this diffuse construct. To address this need, the RCOPE was developed. This inventory came to be in the wake of mounting evidence linking religion, spirituality, and mental health outcomes. While acknowledging the diversity in opinion among religious scholars as to exactly what role belief and ritual play, Pargament and colleagues proposed five key areas in which religiosity may function to modify the bereavement experience. Each area represents a list of 5-25 items for the bereaved to endorse or not, comprising the entire instrument. The first is meaning. The subject of an entire theory itself, meaning making is perhaps the most obvious benefit offered by religion. There is little doubt that many people frame the experiences of their life within the context of religious understanding. If this is a helpful and ubiquitous strategy in the everyday lives of millions of people, it is reasonable to assume the this effect would be maintained or magnified in the wake of intense emotional experiences e.g. traumatic grief. Related to meaning, religion may also provide an effective means for achieving a sense of control over the circumstances. Religion may offer additional resources in this respect as many bereaved may feel that they can work in partnership with their concept of the divine to gain mastery over their situation.

Next is comfort. First popularized by Sigmund Freud, the basic idea here is that religion is a coping mechanism by which the individual can achieve a sense of safety in a world wrought with cruel and seemingly indiscriminate disaster. The role of religion in coping with traumatic loss extends beyond the individual however. That religion aids in social cohesiveness is
uncontroversial, but that this fact has important consequences for the coping process is another one of the insights that the RCOPE attempts to capture. Of the hypothesized benefits of increased social solidarity in the case of bereavement is an increased sense of belonging and a strong social identity in the wake of losing a relationship that may have served these purposes. In a similar way, religion may also aid in the sudden loss of intimacy by allowing the individual to feel part of community of like-minded individuals and even to experience a deeper communion with their conception of divinity.

The final category of the function of religion in the context of traumatic grief that the RCOPE considers is that of life transformation. To this end, religion may offer the resources necessary for the individual to make the transitions inherent to loss. On this criterion, the RCOPE is examining whether religious belief may be a springboard toward making positive life changes through the course of adjustment post loss. The Brief RCOPE, a truncated version of the same instrument, though inspired by Pargament’s five hypothesized benefits to religiosity, further distills the religious coping into two broad categories: positive and negative religious coping strategies. Positive religious coping denotes a relationship between religious belief and the grieving process that is straightforwardly beneficial. Negative religious coping in contrast, denotes an additional spiritual struggle on top of the grief already being experienced. (Pargament 1998).

In order to further isolate what it is specifically about religiosity that may aid in adjustment post loss, many researchers have investigated more thoroughly the role of meaning within the coping process, which eventually led to the formulation of the meaning making
This model of coping views the distress associated with traumatic grief as a disjunction between the perceived meaning of the event and the global sense of meaning. Reappraisal of the loss, recasting it in terms more congruent with an individual’s global theory of meaning is the hypothesized mechanism by which the cognitive dissonance and accompanying psychological turmoil are mediated (Park 2008). Religious belief and ritual, in this model, facilitate the incorporation of the loss into an integrated worldview. Instead of an isolated, senseless tragedy, religion may provide a convenient means for reframing the loss. The relationship between meaning making and religion might appear obvious, but the correlation has been observed to be a complex one, highly dependent on individual orientation, the nature of the belief system, and a host of other factors. In practice, the question of whether religion aids in coping seems to yield context sensitive answers, suggesting that there may be a genuine benefit, but the effect is hardly a straightforward one.

As such, descriptive studies have found some verification for the predictions of the meaning making model. Religious coping, it has been observed, often plays an especially prominent role with respect to finding existential meaning after loss (Lord 2014). Now how it is exactly that religiosity alters grief cognition is an open question, though one common measure of grief outcomes is the extent to which the bereaved ruminate on their loss or avoid grief reminders (Shear 2011). Indeed, one of the most obvious symptoms when diagnosing CG is an intense and persistent feelings of longing. Perhaps the minimization of such grief related ruminations is the mechanism by which the benefits of religiosity manifest. Or perhaps a hypothesis even more in line with the meaning making model is correct, namely, that grief cognitions are not reduced so much as recast in more positive terms. The first step in answering
these questions is to characterize the rate at which individuals turn to religious coping in traumatic loss and whether this strategy is at all correlated with improved outcomes.

To test this idea, the current study will analyze a sample which completed the ICG in conjunction with the Brief RCOPE to investigate the relationship between grief symptomology and religiosity. These variables will be investigated in the context of a population of individuals who have been bereaved traumatically (ie as a result of accident, homicide, or suicide) and have already met criteria for complicated grief per ICG standards.
Research question:

1. Do traumatically bereaved individuals rely more on positive and/or negative religious coping compared to non-traumatically bereaved?

2. Is positive/negative religious coping associated with grief outcomes?

Hypotheses:

1. Traumatically bereaved individuals will be more likely to utilize positive religious coping strategies than the non-traumatically bereaved.

2.
   a. Positive religious coping will be associated with lower grief severity (i.e. lower ICG scores).
   b. Negative religious coping will be associated with higher grief severity (i.e. higher ICG scores).
Methods

Participants

42 bereaved participants who experienced child and/or spousal loss participated in the study.

- 11 participants: bereaved \textit{traumatically} (homicide, suicide, or accident)
- 31 participants: bereaved \textit{non-traumatically}

Recruitment

Participants were recruited through fliers, bereavement support groups, and local obituaries for a separate study comparing child and spousal loss.

Instruments

The ICG assesses CG with self-reported measures on a five point scale ranging in how often the given symptom was experienced from “always”, “sometimes”, and “never”. It employs questions aimed at the specifically CG associated -symptoms, loss rumination and longing, such as: “I think about [the deceased] so much that it’s hard to do the things I normally do,” and, “I feel myself longing for the person who died,” and, “I feel that life is empty without the [the deceased].”

The Brief RCOPE measures positive and negative religious coping on a four point scale over 14 questions, based on how often each statement was true for the participant in the coping process ranging from “All the time” to “Not at all”. Half of the scale focuses on positive religious coping (e.g. “Sought God’s loving care”) while the other half focuses on negative religious
Procedure

Participants gave informed consent and completed the ICG and Brief RCOPE online and on paper.

Description of Study Participants

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Figure 1. Sociodemographics and Loss Related Variables
Results

Research Question 1

Do traumatically bereaved individuals rely more on positive and/or negative religious coping compared to non-traumatically bereaved?

Traumatically bereaved individuals were more likely to use positive religious coping strategies ($M = 18.40, SE = 2.77$) than the non-traumatic group. ($M = 16.32, SE = 1.48$). This difference was significant, $t(30.71) = 2.45, p < 0.05$ and represented a medium effect size $r = .40$.

Traumatically bereaved individuals were more likely to use negative religious coping strategies ($M = 9.40, SE = 1.19$) than the non-traumatic group. ($M = 8.31, SE = 4.24$). However, the difference was not significant, $t(11.40) = -0.87, p > 0.05$ and represented only a small effect size, $r = .062$. 
Research Question 2

Is positive/negative religious coping associated with grief outcomes?

It was found that positive religious coping was weakly related with decreased CG symptoms as measured by decreased ICG scores, $t = -0.24$, $p = .11$.

Figure 2. The relationship between grief symptoms and positive religious coping.
Research Question 2 Cont’d

Is positive/negative religious coping associated with grief outcomes?

In the opposite case, it was found that negative religious coping was strongly related with increased CG symptoms as measured by increased ICG scores, † = 0.49, p = 0.02

Figure 3. The relationship between grief symptoms and negative religious coping.
Discussion

With respect to the first research question, whether the traumatically bereaved are more likely to use positive or negative religious coping, the results were twofold. The first significant finding of this study was that the traumatically bereaved group was on average more likely to utilize positive religious coping strategies compared to the non-traumatic group. This perhaps helps to explain previous findings in the literature where religious belief has been correlated with lower grief severity. When the bereaved are more likely to employ positive religious coping strategies, they may be more inclined to find positive meaning from their personal tragedy, as predicted by the meaning making model. One important limitation of this finding, as is the case with all correlational investigations, is that it is unclear whether positive religious coping causes improved grief outcomes or whether individuals who are successfully coping for other reasons possess a proclivity towards positive religious coping. Future studies may want to investigate the exact nature of this complex relationship.

Next, it was found that the traumatically bereaved group was also slightly more likely to utilize negative religious coping strategies than the non-traumatic group. This tendency was not statistically significant, however (p>.05). Assuming the existence of an actual effect in this direction, this prediction is again in line with Park’s meaning making model (Park 2008). Regardless of the positive or negative nature of the religious coping, the worldview-shattering power of losing a loved one to homicide, suicide, or accident, may demand compensatory measures that involve any kind of spirituality. Because of the suddenness and unexpectedness of the event, one result that may complicate the grieving trajectory is the loss of an individual’s sense of safety or their trust in the basic goodness of the world. Future investigations may be
able to determine what is underneath the relationship of negative religious coping to traumatic loss. Of great clinical significance would also be a greater understanding of the factors that may redirect a bereaved person from negative to positive religious coping.

For the second research question, we wanted to know if religious belief was correlated with grief outcomes. In accordance with our second hypothesis, it was found that positive religious coping was negatively correlated with ICG scores. That is to say, the use of positive religious coping strategies was related to less grief symptomatology and improved grief outcomes. This makes sense because positive religious coping is attempting to measure a straightforwardly beneficial relationship between religious belief and coping. However, this result was not statistically significant (p>.05). In the case of negative religious coping, we expected to find exactly the opposite, which was the result we discovered. The use of negative religious coping strategies was correlated with higher ICG scores (i.e. higher grief severity and worse grief outcomes). Again, this finding is consistent with Park’s meaning making model. Because negative religious coping denotes an additional spiritual struggle, the increased grief severity that we measured as associated with these strategies may plausibly be the result of such obstacles to successful meaning making.

Because there is relatively little research looking specifically at religiosity and traumatic bereavement, there are a breadth of opportunities to build on these results. Future studies may begin by investigating mediating variables between positive/negative religious coping and grief symptoms in traumatically bereaved populations. Also, larger and more diverse sample sizes may avoid the limitations of our group which was relatively small and predominantly white, female, Western, and Christian. Also, because the RCOPE is primarily aimed at monotheistic
religions, future studies may want to examine spiritual frameworks which may not readily fit into the scope of the instrument.
Bibliography


