

The Role of Hope in Bereavement for Chinese People in Hong Kong

AMY Y. M. CHOW

Department of Social Work & Social Administration,
The University of Hong Kong, Hong Kong

Address: Correspondence to Amy Chow, Assistant Professor, Department of Social Work & Social Administration, The University of Hong Kong, Pokfulam, Hong Kong. Email: chowamy@hku.hk

The work described in this paper was substantially supported by a grant from the Research Grants Council of the Hong Kong Special Administrative Region, China (Project No. HKU 7110/01H). The author would like to extend the gratitude to Professor Cecilia Chan and Dr. Samuel Ho for their valuable input in designing the study described in this paper. The authors would also like to express their sincere gratitude to the staff of the Jessie and Thomas Tam Centre (JTTC), the Society for the Promotion of Hospice Care and Nam Long Hospital of Hospital Authority in Hong Kong for their support and assistance given to this study.

Running head: The Role of Hope in Bereavement for Chinese People in Hong Kong

The Role of Hope in Bereavement
for Chinese People in Hong Kong

Amy Y. M. Chow

University of Hong Kong

Author's Manuscript

Abstract

This study examined the relationships between hope and the emotional reactions of bereaved Chinese people in Hong Kong. Three groups: a clinical bereaved sample ($n = 140$), a general bereaved sample ($n = 152$), and a non-bereaved comparison sample ($n = 144$) were included. Significant differences in three hope measures, hope (pathway), hope (agency) and hope (total), were found between the three groups. Moderately strong correlations were found between hope measures and emotional reactions. A mediating effect for hope (agency), but not for hope (pathway) and hope (total), was found in the relationship between bereavement. Possibilities for working with Chinese bereaved people and implications for research and training were discussed.

Hope is commonly considered a therapeutic or healing factor across psychotherapies (Karren, Hafen, Smith & Frandsen, 2002; Snyder, Michael, & Cheavens, 1999). There is a growing interest in studying the role of hope in different contexts (for a review see, Snyder, Rand, and Sigmon, 2002). Examples include patients with life threatening illness and their family members (Benzein & Berg, 2005; Geiling, 1999; Harris & Larsen, 2008, Herth, 1993; Little & Sayers, 2004), older adults receiving psychotherapy (Bergin & Walsh, 2005), people who become disabled (Smith, & Sparkes, 2005), and people who are traumatized (Ai, Cascio, Santangelo, & Evans-Campbell, 2005). Although hopelessness is more commonly examined in bereavement than its antonym – hope - there are attempts to link these two concepts in theoretical and empirical studies. Gamlin (1995) promoted the use of hope in helping bereaved people fifteen years ago. Cutcliffe (1998, 2004a, 2004b) extended his interest in hope from the area of end-of-life care to bereavement. Michael and Snyder (2005) recently established a model of hope in the adjustment to bereavement. Other scholars in the area of bereavement have also paid attention to the concept of hope. Attig (2004) proposed that affirmation of hope in the agony of loss was one of the fundamental tasks in supporting the bereaved. Chow (2006) identified future-orientation as one of the themes in her exploratory study of bereaved people in

Hong Kong. The research reported here is an extension of that exploratory study, examining the role of hope in the bereavement experience of Chinese people.

Hope

Hope is an elusive concept. The title of a book chapter – *Hope: Many definitions and many measures* – reflects this reality (Lopez, Snyder, & Teramoto-Pedrotti, 2003).

Hope can be conceptualized as emotionally-, cognitively-, or behaviorally-based construct or a combination of all three, although Lopez and colleagues have a preference for viewing it from a cognitive perspective. Farran, Herth and Popovich (1995) alternatively understand hope as an experiential process, a spiritual/transcendent process, a rational thought process, and a relational process.

Nekolaichuk, Jevne and Maguire (1999) identified a three dimensional hope structure (personal, situational and interpersonal) through an empirical study of the meaning of hope. The personal dimension includes items of meaning, vibrancy, engaging, caring and value. The situational dimension centres around the theme of risk including predictability and boldness. The interpersonal dimension is about authentic caring for the person including credibility and comfort. These findings propose a holistic, dynamic and multidimensional structure of hope. Thus, the complexity and diversity of the concept complicates its operationalization in empirical studies.

Within the cognitive dimension, hope has been perceived as an aspect of

goal-attainment (Stotland, 1969). Snyder, Irving, and Anderson (1991) built on this notion and viewed hope as an indication that individuals actively pursue their goals. Hope is considered as “a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy), and (b) pathways (planning to meet goals)” (Snyder, Irving, et al., 1991, p 287).

At the same time, Snyder, Harris, et al. (1991) developed and validated a self-reported measurement tool for hope. Snyder (2002) further extended the definition into a theory of hope that postulates relationships between the three core concepts – goals, agency, and pathways. Goals are targets of mental action sequences, which can be varied in temporal frame and must be attainable. They must embody value systems for actions by the individual. Pathways are the workable routes to the goals, whereas agency is the perceived competence to use one’s pathways to reach goals. The theory suggests that agency and pathway are additive and iterative. In sum, these two factors are required in the formation of the hope construct. The hope measurement scale has been used to test the theory and examine the role of hope in different contexts (Snyder, 2002; Snyder, Rand, et al., 2002). This definition and scale were adopted for this study.

Hope and Adjustment

Snyder (2002) extensively reviewed the research on hope in different contexts.

He concluded that levels of hope are correlated with, and even predict, better academic performance (Snyder, Shorey, et al., 2002). In the area of health promotion, hope has been found to play a significant role in primary and secondary prevention in physical health care programs. It correlates with utilization of health information, involvement in health-related activities, and engagement in preventive behaviors. Hope has even been found to facilitate adjustment in patients in different disease groups (Snyder, 2002). Parenteau, Gallant, Sarosiek and McCallum (2006) found a significant negative correlation between hope and depression and anxiety for patients with gastroparesis. They also found that hope level at baseline accounted for about 10% of depression level at 3-month and 6-month intervals post surgery. Benzein and Berg (2005) studied the correlates of hope in patients and family members in palliative settings. They found that hope was correlated inversely with hopelessness and fatigue, but positively with age. Hope levels among family members were lower than those of the patients. Thio and Elliot (2005), studying hope in women with postpartum depression, found a negative correlation between hope levels and postpartum depression. Hope was found to be inversely correlated with depression and anxiety. In sum, hope is consistently found to be correlated positively with performance and adjustment, and negatively with symptoms across a range of situations.

Hope and Bereavement

Death of a loved one, to some bereaved persons, is also the death of the future.

With their loved one's death, their goals vanish and their future shatters. Themes about the future, for example lost dreams (Gamino, Hogan, & Sewell, 2002), a foreshortened sense of future (Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 1997), a sense of disrupted future (Bonanno & Kaltman, 2001), and feeling hopeless about the future (Shuchter & Zisook, 1993) have been identified in qualitative studies of bereaved persons. Hogan, Worden, and Schmidt (2003-2004) also included the future holding no meaning or purpose, which was further reduced to a bleak future by Parkes (Prigerson & Maciejewski, 2005-2006), as one of the criteria of complicated grief. A distorted sense of future can be a significant reaction to bereavement.

Orientation towards the future is a common key element of hope (Cutcliffe, 2004a; Geiling, 1999; Snyder, 1995) despite diversified definitions. Clearly hope should be included in any examination of the experience of bereavement, although this seems to happen surprisingly infrequently. Gamlin (1995) called attention to the necessity of using hope to cope with loss and grief. He proposed directions and strategies in communication with patients and carers that included hope. Cutcliffe (1998) also linked hope with complicated bereavement reactions and proposed the possibility of inspiring hope at different stages of bereavement. He examined the use

of hope in bereavement counseling in a qualitative study from which he constructed a model with a core variable – the implicit projection of hope and hopefulness - developed through three sequential subcore variables: forgoing the connection and the relationship, facilitating a cathartic release, and experiencing a good ending (Cutcliffe, 2004 a & b). Recently, Attig (2004) attempted the conceptual link of hope to bereavement. Using Doka's (2002) model, Attig claimed that disenfranchisement of grief is a social, political and ethical failure - the failure to respect suffering. He proposed enfranchising hope and love as a way to counteract this failure. Hope is the griever's trust that suffering can be transcended and that they can thrive, and is believed to be an important element in supporting grievers.

The only piece of research on hope and bereavement that could be found using PsycINFO was by Michael and Snyder (2005). They postulated and tested a model of hope, cognitive processing, and adjustment to bereavement. They originally predicted that hope was related to adjustment in bereavement through the cognitive processes of benefit finding and rumination. Results indicated that hope was independently related to psychological well-being, and not indirectly through cognitive processing.

Although hope has a unique role in adjustment to bereavement, the process and mechanism is still a mystery that has to be explored in further studies.

In an exploratory study of the bereavement experiences of Chinese persons, Chan et al. (2005) identified four major themes that included meaning making, bond continuation, support and transformation. Under the theme of meaning making, an important sub-theme – the life of the bereaved after the loss- was found to be important in the adjustment process of widows. The belief in an afterlife fosters a sense of hope for reunion that supports them moving on. Markus and Kitayama (1991) have suggested that people from some cultures that value collectivism, including Chinese, have a tendency to place others, rather than themselves, in a more important or at least an equal position in their lives. The phenomenon has been described as relational orientation (Ho, 1993, 1995), social orientation (Yang, 1993), or other-oriented self (Ho, Saltel, Machavoine, Rapoport-Hubschman, & Spiegel, 2004). Bereaved people who tend to be other-oriented may have more extreme reactions when faced with loss. In my clinical experience, it was not uncommon to hear a Chinese client say, “I am happy if my family are happy. My life goal is to make them happy.” The death of their loved ones then brings their life goal to an end and decimates their vision of the future. In such a situation people frequently report a sense of hopelessness. In an exploratory study of Chinese widows, Chow (2006) identified future-orientation as one of the themes of coping. Most of the widows enjoy reminiscing about past experiences with the deceased and view the future as distant

and shattered. Yet, when their vision could encompass a future, it seemed that they found sufficient reason to carry on. This insight, grounded in the experience of bereaved persons and the literature, led to quantitative research on the role of hope, a future-oriented construct, with bereaved respondents in Hong Kong. In this study, there are two hypotheses. Firstly, it is hypothesized that hope, as well as its components of pathway and agency, would be correlated with emotional reactions. Secondly, the moderating effects of hope, and its derivatives, are postulated in the relationship between bereavement status and emotional reactions.

Method

Participants

The participants in this study were from three groups: two groups of bereaved persons who had lost a spouse or a parent through death and a non-bereaved comparison group. The first group, the clinical bereaved sample, was recruited from a community-based bereavement counseling center. Invitations were extended to 302 individuals known to the centre. There were 140 completed questionnaires received, a response rate of 46.4%. The second group, the general bereaved sample, was recruited from a cancer hospital. Those who were receiving bereavement counseling support from the hospital were excluded from the study. Invitations were sent to 956 individuals whose family members had passed away in the hospital. 152 completed

questionnaires were received. Excluding the 46 undeliverable letters, the response rate for this group was 16.7%. The third group was a comparison group recruited from the university and through a health magazine. Those aged over 18 with no bereavement experiences in the previous two years were invited to join the study. Only those who agreed to join were given the questionnaires. Recruitment stopped when the number of respondents in this group matched the size of the other two groups: 144 completed questionnaires were received with 90 (62.5%) from the University and 54 (37.5%) from the magazine. Ethical approval was obtained from the departmental research ethics committee and the medical Institutional Review Board.

The demographic data are shown in Tables 1 and 2. There is a large difference in the gender ratio between the clinical bereaved sample and the general bereaved sample due to the disproportionate population pool and different response rates of men and women. Thus we should use caution in interpreting gender related findings in these two groups. The gender differences in the two bereaved sample groups would not affect the testing of hypotheses. The correlation between hope and bereavement outcomes are tested on the combined bereaved sample groups, rather than on the clinical bereaved group and general bereaved group separately. The hypotheses of moderating effects are tested between the combined bereaved group and the comparison group. As shown in column 3 and 4 of Table 1, the gender ratios between

these two groups are compatible.

The clinical and general bereaved groups had a similar spread in age: nearly 60% of the respondents were middle aged, 20% in early adulthood, and 20% in late adulthood. In the comparison group, there was a slight skew towards younger age. The majority was middle aged (more than 50%) but only 2% of respondents were in late adulthood. The proportion in early adulthood was about 46%. Although age differences are not likely to account for the differences in findings between the clinical and general bereaved groups, it should be considered as a factor affecting the findings between the combined bereaved group and the comparison group.

The information related to bereavement was only relevant for the two bereaved groups. The majority of the participants experienced spousal loss. Cancer was the major cause of death, as one of the study sites was a cancer hospital. Other causes of death, including sudden deaths, were reported by the participants recruited from the bereavement counseling center. The means of the length of time that had elapsed between the death of the deceased and the participants completing the questionnaires were 15.04 ($N=139$, $S.D.$ 7.77) and 17.43 ($N=146$, $S.D.$ 7.93) months for the clinical and general bereaved samples respectively.

Procedures

A questionnaire in Chinese and an invitation letter were sent to potential

participants. The letter explained the rationale and potential contribution of the study and was signed by both the directors of the organizations and the Director of the Centre on Behavioral Health of the university under whose auspices the study was conducted. An information sheet on the research, two consent forms, and a stamped return envelope were also included. The consent forms included the statement “If you would like to talk to someone about your responses after filling out the questionnaire, please contact...” to minimize the risk of inducing stress in the participants. The questionnaire pack for the non-bereaved group was similar to that of the bereaved group but excluded the questions on bereavement.

Measures

The Hospital Anxiety and Depression Scale (HADS) (Leung, Wing, Kwong, Lo, & Shum, 1999; Zigmond, & Snaith, 1983) was used to measure mood, emotional distress, anxiety and depression in clinical samples with symptoms of physical disease. It has only 14 items, 7 that measure anxiety and 7 for measuring depression. The Chinese-Cantonese version yielded a good internal reliability. The alpha for the full scale was 0.86, and for the depression subscale and anxiety subscale 0.82 and 0.77 respectively. The validation study of the Chinese-Cantonese version of HADS (Leung et al., 1999); suggested the optimal cut-off points for detecting psychiatric cases were 15/16 for the full scale and 8/9 for the depression subscale. HADS was

chosen for the purpose of testing the moderating effects of hope on the relationship between bereavement status and emotional reactions.

The Hope Scale (Snyder, Harris et al., 1991) contains 12 items: four items tap the pathways component, four tap the agency component, and four are distracters.

Eight responses, from 1 as definitely false to 8 as definitely true, are available for each item. The overall score is the summation of the scores for the 8 items related to agency and pathway. At the validation stage, the scale demonstrated both internal reliability and temporal reliability. The range of Cronbach's alpha

was .74–.88, .70–.84, and .63–.86 for the overall score, agency score and pathway score respectively. The test-retests were all over .80 for both 3 weeks and 10 weeks.

The typical mean score for the scale was 49; the standard deviation was 7. The English version was translated into Chinese-Cantonese with back translation. In the current study, the overall score, agency score and pathway way score of the Hope Scale had Cronbach's alphas of .90, .74, and .89 respectively (Snyder, 2002).

Results

Descriptive Statistics

The hope level of the clinical bereaved sample is significantly statistically lower than that of the general bereaved sample. That is, bereaved people in the clinical sample are less likely to identify pathways to work towards goals and at the same time

are less motivated to try out the pathways than those in the general bereaved sample. Similarly, the hope level of the combined bereaved sample is lower than that of the comparison group. For details, please see Table 3. A further comparison between the general bereaved sample and the comparison group found that there was still a significant difference. Because of the differences in age and gender, a number of ANCOVAs were carried out and statistical differences between the means still existed after controlling for age and gender.

Zero-order Correlations

The zero-order correlations between hope measures and emotional reactions among the bereaved sample, non-bereaved sample and all respondents are given in Table 4. Moderately strong and statistically significant correlations (r ranging from $-.365$ to $-.601$, $p < .01$) are found between the hope measures and *HADS* in analyzing all the respondents. The negative correlations imply that the higher hope level is associated with the lower scores on the outcome variables of depression and anxiety. The result supports our first hypothesis that hope is correlated with emotional reactions. When we analyze the bereaved and non-bereaved respondents separately, a similar pattern is observed. The correlations between hope measures and emotional reactions in the bereaved samples are higher than those in the non-bereaved samples, implying a stronger relationship in the bereavement sample.

Moderating Effect

Moderators help us to understand when, under what circumstances, or for whom a predictor variable influences a dependent variable (Frazier, Tix, & Barron, 2004).

We hypothesized that hope levels affect the relationship of bereavement status to emotional reactions. Measures of hope (pathway), hope (agency) and hope (total) were analyzed separately with the two emotional outcomes of HADS (anxiety) and HADS (depression). A preliminary screening was carried out through partial correlations between bereavement status and emotional reactions, controlling for the three hope measures. If a difference is found between a correlation and a partial correlation, there is a higher possibility of a moderating effect. Then a 2-way ANOVA was used to test the moderating effects. When analyzing the interaction effect of a predictor (bereavement status) with a potential moderator (hope (pathway), hope (agency), or hope (total)), a significant effect implies the existence of a moderating effect.

As indicated in Table 5, there are significant differences between the correlations and partial correlations that control the respective hope dimensions. The changes in r^2 ranged from -.032 to -.065, implying a reduction in explained variances from 3.2% to 6.5% when parameters of hope were controlled. This was followed by ANOVA using the three hope parameters with the emotional reactions.

Using the split half method, hope scores (agency, pathway, and total) were dichotomized into high/low (1=low, 2=high). Bereavement status was coded as 1 for the bereaved group and 0 for the comparison group. The F-values of interaction effect in the 2-way ANOVA are shown in Table 6. Of the six interaction effects, only that of Bereaved Status X Hope (agency) on Bereaved Status with Anxiety was significant.

For a clearer presentation, the interaction effect over anxiety is illustrated diagrammatically in Figure 1. However, the lack of intersection between the two lines suggests the moderating effect is not a very large one. However, the slope change still indicates a moderating effect on the strength of the relationship. The result implies that high hope (agency) level reduces the strength of the relationship between bereavement and anxiety. The hypothesis that hope acts as a mediator on the relationship between bereavement and emotional reactions was partially supported. Hope (agency), but not hope (pathway) or hope (total) was identified as a statistically significant mediator.

Discussion

The correlations between hope and the emotional reactions are negative, implying that a higher level of hope is associated with a lower level of anxiety and depression. This suggests that inducing hope, through identification of future goals, identification of pathways to achieve goals, and increasing motivation to use the

pathways, is a strategy to decrease anxiety and depression.

The hope score was found to be significantly lower in the bereaved group than in the non-bereaved group, even after differences in age distribution were taken into account. Traumatic life events that include bereavement shatter assumptive worldviews (Janoff-Bulman, 1992). In addition, perceptions of the future are also shattered. The bereaved person's ability to identify desired goals for the future becomes impaired. They may even be unwilling to identify one as they could not or would not want to believe that they have a future apart from the deceased. The strongest desire of nearly every bereaved person is to bring their loved one back to life. This goal, however unrealistic, tends to dilute the importance of other, more achievable, goals. Even if they are willing and able to identify goals, they might have difficulty in finding pathways to achieve them. This is reflected by the lower hope (pathway) score, possibly caused by a lower sense of self-trust and self-efficacy when faced with the uncontrollable event of bereavement. Even when they have confidence in identifying pathways to desired goals, motivation may remain a problem. "What is the meaning of living without the deceased?" was a question that the bereaved people with whom I worked commonly asked.

Further analysis of the moderating effect of hope on the relationship between bereavement and emotional reactions found that hope (agency) is the only component

that has any significant moderating effect. That is, when someone has low motivation in moving towards a goal in the future, he or she is more likely to be affected adversely by the bereavement experience. This information can be used as one of the assessment parameters in the identification of at-risk individuals.

The Possible Role of Hope in Assessment of Bereaved Persons

The moderately strong correlations between emotional reactions and hope measures imply that given the hope measures, we can estimate the level of emotional reactions. Thus instead of asking our bereaved clients to fill in measurements of depression or anxiety, which usually include items describing negative mood states, we can ask them to fill in the hope scale consisting of positive statements. Examples include “I can think of many ways to get out of a jam”, or “My past experiences have prepared me well for my future”. These statements could have an encouraging impact on bereaved people who are temporarily distressed. Besides, if the intervention is geared towards hope induction, then taking hope as an outcome measure is more relevant.

On the other hand, the analysis of moderating effects tells us who is more easily affected by bereavement and under what circumstances. The findings of the research concerning the moderating effects of hope provide directions for the identification of those who are more easily affected by bereavement. As suggested by the Centre for

the Advancement of Health (2003), not all bereaved persons are in need of or benefit from bereavement counseling. Thus screening for those at high-risk to determine provision of services can help in setting priorities when resources are limited. The identification of hope (agency) can be one domain for screening. Recently, Snyder and his colleagues concretized this idea by putting forward a framework for client assessment reports that included hope (Snyder, Ritschel, Rand, and Berg, 2006).

The Possible Role of Hope in Working with Bereaved Persons

The relationship of hope to bereavement outcomes is a new discovery, which gives direction to caring for the bereaved. These findings advance the central theme of Cutcliffe (2004a, 2004b, 2006a, 2006b) who emphasized the inspiration of hope in bereavement counseling. This study identified agency as the only one of the three parameters of hope that had a moderating effect on the relationship of bereavement to emotional reactions. Therefore, the crucial focus of intervention of hope-based bereavement counseling should not be on creating plans for reaching important goals (pathways) but on increasing determination to put these plans into action (agency). For bereavement counselors or carers of bereaved persons, talking about goals and plans for the future is insufficient to work through the emotional and physical outcomes of bereavement. It is more important to find ways to motivate, as well as support, the implementation of actions towards these goals.

Lopez et al. (2004) have devised methods for hope-based therapy. They proposed four essential strategies in accentuating hope: hope finding, bonding, enhancing and reminding, complete with detailed possible actions and steps. This provides a rich pool of ideas on how to inspire hope through the counseling process. Although these strategies are originally proposed for general situations, the suggested steps appear to be relevant and feasible in working with bereaved persons. Specifically, the actions and steps suggested under hope enhancing are relevant for facilitating the development of hope agency. Further research in studying the effects of applying these strategies in bereavement counseling would be valuable.

The findings of Cutcliffe (2004a, 2004b, 2006a, 2006b) offer another important insight into hope inspiration in bereavement counseling - the importance of staff support in providing hope-based bereavement counseling. Counseling is a dialectic process. The hope levels of counselors inevitably affect the hope levels of clients. As suggested by Frank and Frank (1991), a relationship with a therapist who is hopeful is one of the therapeutic factors in psychotherapy irrespective of the models adopted. Snyder et al. (1999) suggests that the counselor's trust in the potential for change in the client is of equal importance. Counselors who are burnt out and have low levels of hope are poor models in hope (pathway) and hope (agency) thinking for clients. Thus, examining the hope levels of bereaved clients is not adequate. Equal attention should

be paid to the counselors who are supporting the bereaved persons. Alongside knowledge and skill training for potential bereavement counselors, the emotive and personal values regarding hope are of equal importance. This suggestion is coherent with my observations as a trainer in bereavement counseling. Some trainees demonstrated competence in knowledge and skills, but found it difficult to work with bereaved people. Upon exploration, I commonly found that the barrier lay in their personal bereavement experiences. They saw no hope in working on their own loss experiences and avoided dealing with them. Thus, they had no sense of competence in working with bereaved persons. Even when they tried, there was a chance they would inculcate a sense of hopelessness rather than hope. Thus besides emphasizing the importance of the inspiration of hope in bereavement counseling, developing a good system of staff support in the form of clinical supervision, reflective workshops or supportive bereavement counseling services for counselors is important.

Limitations of study

Despite the careful planning and conscious effort to maintain rigor, there are several limitations that should be noted.

At the level of design, the study is limited by its cross-sectional nature. All conclusions about prediction are understood in a statistical sense rather than a causal sense. Where adequate resources are available, longitudinal studies are preferable.

At the level of sampling, the response rate of the clinical and non-clinical bereaved sample is 46.4% and 16.7% respectively. Taken at face value this can be considered a low response rate. The representativeness of the sample is then vulnerable to challenge. For studies on bereavement carried out in western countries, it is common to recruit through reading obituaries or via the office of the official Registrar of births and deaths. However, it is not common to place obituaries in newspapers in Hong Kong and the registration of births and deaths is bound by the *Privacy Ordinance*. Because of the limited understanding of bereavement research in Hong Kong, the present recruitment method seems to be the best available.

The comparison of the characteristics of the dropouts with those of the participants in the clinical sample indicated that there were no significant differences in demographic data. However, the differences in the psychological and social dimensions cannot be tested. In addition, no background data from the total pool of the non-clinical sample could be obtained. Thus, knowledge of how representative the participants were of the non-respondents was limited. Moreover, the comparison group had a relatively younger mean age and a higher education level than the bereaved group.

At the level of analysis, there is problem related to dichotomizing the hope measures in the two-way ANOVA in examining their moderating effect. The

independent variable is a categorical one - bereavement status - while the mediator (the hope measures) is a continuous variable. Thus the scales for the latter had to be converted into categorical scales. The conversion process reduced the level of information available, and the choice of the cut-off point was debatable.

Conclusion

Despite these limitations, this study is among the few available that examines hope in the context of bereavement and is the first study in this area on a Chinese population. The study has extended the understanding of the relationship between bereavement and hope from a theoretical model to an empirically tested model, with a non-bereaved comparison group. The methodology also expanded from correlational findings to the study of moderating effects. Findings have implications for future research. In addition to the significant negative correlations found between hope, and anxiety and depression, only one component of hope - agency - was found to have a moderating effect on the anxiety and depression experienced by bereaved respondents. This finding has valuable practice implications for health care professionals who are assessing and supporting bereaved individuals. It also identifies a new path for further research studies on hope and bereavement. Instead of adopting hope as a uni-dimensional protective factor, exploration of the impact of different dimensions of hope on outcomes can be carried out.

References

- Ai, A. L., Cascio, T., Santangelo, L. K., Evans-Campbell, T. (2005). Hope, meaning, and growth following the September 11, 2001, terrorist attacks. *Journal of Interpersonal Violence*, 20(5), 523-548.
- Attig, T. (2004). Disenfranchised grief revisited: Discounting hope and love. *Omega*, 49(3), 197-215.
- Benzein, E. G. & Berg, C. A. (2005). The level of hope of and relation between hope, hopelessness and fatigue in patients and family members in palliative care. *Palliative Medicine*, 19, 234-240.
- Bergin, L. & Walsh, S. (2005). The role of hope in psychotherapy with older adults. *Aging and Mental Health*, 9(1), 7-15.
- Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychological Review*, 21(5), 705-734.
- Centre for the Advancement of Health (2003). *Report on Bereavement and Grief Research*. Retrieved April 19, 2004, from <http://www.cfah.org/pdfs/griefreport.pdf>
- Chan, C. L. W., Chow, A. Y. M., Ho, S. M. Y., Tsui, Y. K. Y., Tin, A. F., Koo, B. W. K., et al. (2005). The experience of Chinese bereaved persons: A preliminary study of meaning making and continuing bonds. *Death Studies*, 29, 923-947.

- Chow, A. Y. M. (2006). *The bereavement experience of Chinese persons in Hong Kong*. Unpublished doctoral dissertation. University of Hong Kong, Hong Kong.
- Cutcliffe, J. R. (1998). Hope, counseling and complicated bereavement reactions. *Journal of Advanced Nursing*, 28(4), 754-761.
- Cutcliffe, J. R. (2004a). The inspiration of hope in bereavement counseling. *Issues in Mental Health Nursing*, 25, 165-190.
- Cutcliffe, J. R. (2004b). *The inspiration of hope in bereavement counseling*. London: Jessica Kingsley.
- Cutcliffe, J.R.. (2006a). The principles and processes of inspiring hope in bereavement counseling: a modified grounded theory study – Part one. *Journal of Psychiatric and Mental Health Nursing*, 13, 598-603.
- Cutcliffe, J.R.. (2006b). The principles and processes of inspiring hope in bereavement counseling: a modified grounded theory study – Part two. *Journal of Psychiatric and Mental Health Nursing*, 13, 604 – 610.
- Doka, K. (Ed.). (2002). *Disenfranchised grief*. Champaign, IL: Research Press.
- Farran, C. J., Herth, K. A., & Popovich, J. M. (1995). *Hope and hopelessness: Critical clinical constructs*. Thousand Oaks, CA: SAGE.
- Frank, J. D., & Frank, C. B. (1991). *Persuasion and healing* (3rd. ed.). Baltimore: Johns Hopkins University Press.

- Frazier, P. A., Tix, A. P., & Barron, K. E. (2004). Testing moderator and mediator effects in counseling psychology research. *Journal of Counseling Psychology*, 51(1), 115-134.
- Gamino, L. A., Hogan, N. S., & Sewell, K. W. (2002). Feeling the absence: A content analysis from the Scott and White grief study. *Death Studies*, 26, 793-813.
- Gamlin, R. (1995). Using hope to cope with loss and grief. *Nursing Standard*, 9(48), 33-35.
- Geiling, L. (1999). The role of hope for relatives of critically ill patients: A review of the literature. *Nursing Standard*, 14(1), 33-38.
- Harris, G. R., & Larsen, D. (2008). Understanding hope in the face of an HIV diagnosis and high risk behaviors. *Journal of Health Psychology*, 13, 401-415.
- Herth, K. (1993). Hope in family caregiver of terminally ill people. *Journal of Advanced Nursing*, 18(4), 538-548.
- Ho, D. Y. F. (1993). Relational orientation in Asian social psychology. In U. Kim & J. W. Berry (Eds.). *Indigenous psychologies*. (pp. 240-259). Newbury Park, CA: Sage.
- Ho, D. Y. F. (1995). Self-hood and identity in Confucianism, Taoism, and Hinduism. *Journal for the Theory of Social Behavior*, 25(2), 115-139.
- Ho, S. M. Y., Saltel, P., Machavoine, J. L., Rapoport-Hubschman, N., & Spiegel, D.

- (2004). Cross-cultural aspects of cancer care. In R. J. Moore & D. Spiegel (Eds.), *Cancer, culture, and communication* (pp. 157–183). New York: Kluwer Academic
- Hogan, N. S., Worden, J. W., & Schmidt, L. A. (2003-2004). An empirical study of the proposed complicated grief disorder criteria. *Omega*, 48(3), 263-277.
- Horowitz, M. J., Siegel, B., Holen, A., Bonanno, G. A., Milbrath, C., & Stinson, C. H. (1997). Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry*, 154 (7), 904-910.
- Janoff-Bulman, R. (1992). *Shattered assumptions*. New York:Free Press
- Karren, K. J., Hafen, B. Q., Smith, N. L., Frandsen, K. J. (2002). The healing power of hope. In *Mind/Body health: The effects of attitudes, emotions, and relationships* (pp. 511-532). San Francisco, CA: Benjamin Cummings.
- Leung, C. M., Wing, Y. K., Kwong, P. K., Lo, A., & Shum, K. (1999). Validation of the Chinese-Cantonese version of the Hospital Anxiety and Depression Scale and comparison with the Hamilton Rating Scale of Depression. *Acta Psychiatrica Scandinavica*, 100(6), 456-461.
- Little, M., & Sayers, E. J. (2004). While there's life...hope and the experience of cancer. *Social Science and Medicine*, 59(6), 1329-1337.
- Lopez, S. J., Snyder, C.R., Magyar-Moe, J. L., Edwards, L. M., Pedrotti, J. T.,

- Janowski, K., Turner, J. L., & Pressgrove, C. (2004). Strategies for accentuating hope. In P. A. Linley, & S. Joseph (Eds.). *Positive psychology in practice* (pp. 388 – 404). Hoboken, NJ: Wiley.
- Lopez, S. J., Snyder, C. R., Teramoto-Pedrotti, J. (2003). Hope. In S. J. Lopez & C. R. Snyder (Eds.) *Positive psychological assessment*. (pp. 91-107). Washington, DC: American Psychological Association.
- Markus, H.R., & Kitayama, S. (1991). Culture and the self. *Psychological Review*, 98, 224-253.
- Michael, S. T. & Snyder, C. R. (2005). Getting unstuck: The roles of hope, finding meaning, and rumination in the adjustment to bereavement among college students. *Death Studies*, 29, 435-458.
- Nekolaichuk, C. L., Jevne, R. F., & Maguire, T. O. (1999). Structuring the meaning of hope in health and illness. *Social Science and Medicine*, 48(5), 591-605.
- Parenteau, S. C., Gallant, S., Sarosiek, I. & McCallum, R. W. (2006). The role of hope in the psychological adjustment of gastropareptic patients receiving gastric pacemaker: A longitudinal study. *Journal of Clinical Psychology in Medical Settings*, 13(1), 49-56.
- Prigerson, H. G., & Maciejewski, P. K. (2005-2006). A call for sound empirical testing and evaluation of criteria for complicated grief proposed for DSM-V. Omega,

52(1), 9-19.

Shuchter, S. R. & Zisook, S. (1993). The course of normal grief. In M. S. Stroebe, W.

Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement* (pp. 23-43).

Cambridge, UK: Cambridge University Press.

Smith, B., & Sparkes, A. C. (2005). Men, sport, spinal cord injury, and narratives of hope. *Social Science and Medicine*, 61, 1095-1105.

Snyder, C. R. (1995). Conceptualizing, measuring, and nurturing hope. *Journal of Counseling and Development*, 73(3), 355-360.

Snyder, C. R. (2002). Hope theory. *Psychological Inquiry*, 13(4), 249-275.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S.A., Irving, L. M., Sigmon, S. T., et al. (1991). The will and the ways. *Journal of Personality and Social Psychology*, 88, 309-319.

Snyder, C. R., Irving, L., & Anderson, J. R. (1991). Hope and health. In C.R. Snyder, & D. R. Forsyth (Eds.), *Handbook of social and clinical psychology: The health perspective* (pp. 285-305). Elmsford, NY: Pergamon.

Snyder, C. R., Michael, S. T., & Cheavens, J. S. (1999). Hope as a psychotherapeutic foundation of common factors, placebos, and expectancies (pp. 179-200). In M. A. Hubble, B. L. Duncan, and S. D. Miller (Eds.) *The heart and soul of change*. Washington, DC: American Psychological Association.

- Snyder, C. R., Rand, K. L., & Sigmon, D. R. (2002). Hope theory: A member of the positive psychology family. In C. R. Snyder & S. J. Lopez (Eds.) *Handbook of positive psychology* (pp.257-276). Oxford: Oxford University Press.
- Snyder, C. R., Ritschel, L. A., Rand, K. L., & Berg, C. J. (2006). Balancing psychological assessments: Including strengths and hope in client reports. *Journal of Clinical Psychology*, 62(1), 33-46.
- Snyder, C. R, Michael, S. T., & Cheavens, J. S. (1991). Hope as a psychotherapeutic foundation of common factors, placebos, and expectancies. In M.A. Hubble, B. L. Duncan, & S. D. Miller (Eds). *The heart and soul of change: What works in therapy*. (pp. 179-200). Washington, DC: American Psychological Association.
- Snyder, C. R., Shorey, H. S., Cheavens, J., Pulvers, K. M., Adams, V. H., & Wiklund, C. (2002). Hope and academic success in college. *Journal of Educational Psychology*, 94(4), 820-826.
- Stotland, E. (1969). *The psychology of hope*. San Francisco: Jossey-Bass.
- Thio, I. M. & Elliot, T. R. (2005). Hope, social support, and postpartum depression: Distinguishing the mediating effects of negative affectivity. *Journal of clinical psychology in medical settings*. 12(4), 293-299.
- Yang, K. S. (1993). Chinese social orientation: An integrative analysis. In W. S. Tseng, T. Y. Lin, & Y. K. Yeh (Eds.), *Chinese societies and mental health* (pp. 19-39).

Hong Kong: Oxford University Press.

Zigmond, A. S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale.

Acta Psychiatrica Scandinavica, 67(6), 361-370.

Author's Manuscript

Table 1

Gender Distribution of the Three Sample Groups

	Clinical Bereaved (JTTC)	General Bereaved (NLH)	Combined Bereaved	Comparison Group
Male	12 (8.6%)	67 (45.0%)	79 (27.3%)	38 (26.8%)
Female	128 (91.4%)	82(55.0%)	210 (72.7%)	104(73.2%)
Total	140 (100%)	149 ^a (100%)	289 (100%)	142 ^b (100%)

^a: There were three missing cases

^b: There were two missing cases

Table 2

Age Distribution in the Three Sample Groups

	Clinical Bereaved (JTTC)	General Bereaved (NLH)	Combined Bereaved	Comparison Group
18-24	1 (0.7%)	10 (6.7%)	11 (3.8%)	8 (5.6%)
25-34	24 (17.1%)	20 (13.4%)	44 (15.2%)	58 (40.8%)
35-44	41 (29.3%)	44(29.5%)	85 (29.4%)	53 (37.3%)
45-54	47 (33.6%)	41 (27.5%)	88 (30.5%)	20 (14.2%)
55-64	13 (9.3%)	20 (13.5%)	33 (11.4%)	2 (1.4%)
≥65	14 (10.0%)	14 (9.4%)	28 (9.7%)	1 (0.7%)
Total	140 (100%)	149 ^a (100%)	289 (100%)	142 ^b (100%)

^a: There were three missing cases

^b: There were two missing cases

Table 3

Mean (*M*) and Standard Deviation (*SD*) of the Hope-scores of Clinical Bereaved,

General Bereaved and Comparison Groups

		Clinical Bereaved (JTTC)	General Bereaved (NLH)	Combined Bereaved	Comparison Group
Hope (Pathway)	<i>M</i>	20.54	23.21	21.93	24.70
	(<i>SD</i>)	(7.17)	(5.98)	(6.71)	(4.24)
	<i>N</i>	134	145	279	143
		(t=-3.37, p=.001)***		(t=-4.50, p=.000)***	
Hope (Agency)	<i>M</i>	17.89	20.82	19.40	22.55
	(<i>SD</i>)	(6.02)	(5.33)	(5.85)	(3.74)
	<i>N</i>	135	144	279	143
		(t=-4.31, p=.000)***		(t=-5.84, p=.000)***	
Hope (Total)	<i>M</i>	38.37	44.01	41.31	47.25
	(<i>SD</i>)	(12.59)	(10.83)	(12.02)	(7.51)
	<i>N</i>	132	144	276	142
		(t=-3.99, p=.000)***		(t=-5.37, p=.000)***	

****p*<.001, ***p*<.01, **p*<.05

Table 4

Correlations Between, Hope (Pathway), Hope (Agency), Hope (Total) Scores and

HADS

	1	2	3	4	5
All respondents (<i>N</i> = 422)					
1. Hope (Pathway)	–	.829**	.961**	-.436**	-.533**
2. Hope (Agency)		–	.951**	-.554**	-.601**
3. Hope (Total)			–	-.512**	-.589**
4. HADS (Anxiety)				–	.756**
5. HADS (Depression)					–
Bereaved respondents (<i>n</i> = 279)					
1. Hope (Pathway)	–	.832**	.963**	-.427**	-.535**
2. Hope (Agency)		–	.951**	-.560**	-.591**
3. Hope (Total)			–	-.509**	-.584**
4. HADS (Anxiety)				–	.752**
5. HADS (Depression)					–
Non-bereaved respondents (<i>n</i> = 143)					
1. Hope (Pathway)	–	.761**	.946**	-.323**	-.377**
2. Hope (Agency)		–	.930**	-.387**	-.468**
3. Hope (Total)			–	-.375**	-.449**
4. HADS (Anxiety)				–	.694**
5. HADS (Depression)					–

***p* < .01

Table 5

Partial Correlation of Bereaved Status and Outcome Variables, Controlling Hope

Dimensions

		No Control	Controlling Hope (Pathway)	Controlling Hope (Agency)	Controlling Hope (Total)
HADS (Anxiety)	<i>r</i>	.243**	.165**	.107**	.126**
	<i>r</i> ²	.059	.027	.011	.016
	(Δr^2)	(.000)	(-.032)	(-.048)	(-.043)
HADS (Depression)	<i>r</i>	.327**	.252**	.205**	.215**
	<i>r</i> ²	.107	.064	.042	.046
	(Δr^2)	(.000)	(-.043)	(-.065)	(-.061)

** $p < .01$, * $p < .05$

Table 6

F-values of Interaction Effect of Bereavement and Hope on Depression, Anxiety and Symptoms

	Interaction Effect of Bereaved X Hope (Agency)	Interaction Effect of Bereaved X Hope (Pathway)	Interaction Effect of Bereaved X Hope (Total)
HADS (Depression)	$F(1,407)=2.767, p=.097$	$F(1,407)=.248, p=.618$	$F(1,403)=1.452, p=.229$
HADS (Anxiety)	$F(1,403)=6.703, p=.010$	$F(1,403)=.158, p=.691$	$F(1,399)=.902, p=.343$

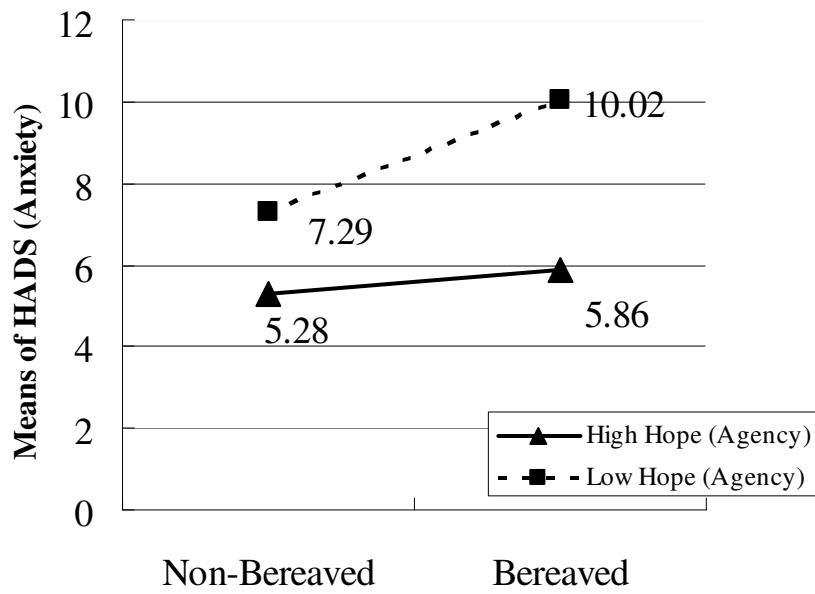


Figure 1: Moderating Effect of Hope (Agency) on the Relationship Between Bereavement and HADS (Anxiety)

Author's Manuscript