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Comprehensive wellbeing and variables linked to religiosity in mothers with children who died

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Abstract

Amongst mourning generating events, death of children is unique, highlighting its impact on female parents (mothers). A group of 22 mothers with children who died and who were linked to religious practices and secular grief support groups was assessed by means of a questionnaire ad hoc (demographic and religious) and the Functional Assessment of Chronic Illness Therapy (FACIT-Sp). Our results showed that Religiosity appears to play a modulatory role against the adverse effects impacting wellbeing generated by the death of a child. It is deemed necessary to pursue this line of research in order to analyse different variables associated with this phenomenon.

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1. Introduction

"Mourning" is a concept that, in our culture, usually refers to the set of psychological and psychosocial processes that follow the loss of a person with whom the affected subject was psychosocially linked (Tizón, 2004). Bowlby (1993) defines mourning as "the psychological processes, conscious and unconscious, that the loss of a loved one sets in train, whatever the result".

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Mourning, in relation with definitive loss of loved ones, implies turning points in stages of life. According to the description provided by Grinberg (1980), living implies going through a series of bereavements; personal evolution transiting through the elaboration of losses and the reestablishment of transitory moments of identity. In pathological cases, should the elaboration of bereavement fail, then serious disturbances in people will sometimes result in pathological states. The loss of a loved one, particularly in a tragic manner, may deeply change the foundations that give sense to the stories of our lives (Neimeyer, 2010).

Mourning has several stages, whose definition and empirical validity has been the subject of much discussion (Maciejewki, Paul, Zhang, Block, and Prigerson, 2007). Nevertheless, mourning has a certain idiopathic character that manifests a significant degree of heterogeneity depending on the affected person. Significant authors such as Parkes (1964), Bowlby (1993) and Worden (1997) have made reference to the subject. Rando (1988), drawing together the common denominator of several contributions, summaries this process by referring to the steps of: a) rejection, b) denial, c) confrontation and d) adaptation.

Within the generating events regarding mourning in adult life we can outline that produced by the death of children, as kinship is significant regarding the difficulty to face the loss (Gamo Medina, del Álamo, Hernangómez, and García Laborda, 2003). Its deep impact is perceived with more intensity in traumatic deaths (accidents, violence, etc.) as stated in literature (Pazos Pezzi & García Eslava, 2000). The death of own children influences relationships with your other living children and with the spouse, causing changes in the interaction with partners.

Religiosity, for its effectiveness in promoting well-being (psychological and physical) and for its role as a strategy for coping with stress, can represent an important therapeutic aid during the mourning process (Koenig, 2004; 2009).

The present study aims to analyze the self-perceived quality of life by mothers who have experienced the death of one of their children through the examination of the statement made by those regarding different parameters that integrate the overall wellbeing of the individual (either physical, emotional, family, social, functional and existential / spiritual wellbeing) . In turn, it intends to investigate further hypothetical accession of those mothers to religious postulates, while examining the potential therapeutic role that spirituality / religiosity could play in better stability and quality of life in those mothers referred.

2. Method

2.1. Participants

The sample showed 22 people who had experienced the death of one of their children. Inclusion criteria included: being female, preserved cognitive ability to interpret the meaning of the questions, and explicit consent to take part in the study. Exclusion criteria included: being under 18 years of age and over 90, as well as the presence of serious mental disease, with ability to interfere with judgment and responses.

The average age of patients was 64.41 years (SD = 9.35), ranging from 41 to 81 years of age. School years showed an average of 9.68 years (SD = 3.35), with a range of 6-17 years of age. The time elapsed from the death of their children ranged from 19 years of age, in this particular case, to hardly a year after the death had taken place (M = 6.05, SD = 5.14). At the same time, their children died at different ages, ranging from 10-40 years of age (M = 28.50, SD = 7.47). Among the different deaths, 18 (81.8 %) were sudden deaths, empathising those caused by work and traffic accidents, whereas those deaths following disease/illness processes, taking longer periods of time, were 3 (13.6 %); there is a case that has not been described.

2.2. Intruments

The following tests were applied:

- Ad hoc questionnaire: through which socio-demographic information was collected, as well as that relating to parameters directly associated with the aim of the study. Information was gathered about the age of the participating woman/mother, her years of schooling, the child's age of death, the number of years since the

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