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The Self-Forgiveness Process of Caregivers After the Death of Care-Receivers Diagnosed With Alzheimer's Disease

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ABSTRACT. This study explores the relationship of self-forgiveness and adaptive coping, religious/spiritual practices, social support, decreased grief, and mental well-being. 133 caregivers were surveyed. Bivariate analysis and stepwise regression models revealed that decreased grief, adaptive coping, and social support were significant in explaining the variation in self-forgiveness. This is one of the first studies to address self-forgiveness as part of the grieving process of Alzheimer's caregivers. Future directions are explored supporting inclusion of self-forgiveness as an aspect of grief and adaptive coping; which is further enhanced by the level of social support experienced by the caregiver.

KEYWORDS. Alzheimer's disease and caregivers, caregiving, self-forgiveness, grief, social support, adaptive coping

Caregivers of family members with Alzheimer's disease (AD) and other chronic diseases are faced with many challenges. A significant challenge for the caregiver is the increased responsibility as it relates to the dual roles of family member and caregiver, which is heightened as the disease progresses. Caregivers of family members diagnosed with AD experience a range of stressors and feelings of helplessness and frustration that can lead to mental distress. These caregivers often experience an increase in the intensity of their feelings of guilt regarding their loved one, and this can significantly increase the amount of time the care-receiver will need to work through their feelings of grief and loss. As it progresses, Alzheimer's disease compromises a person's functioning on many levels. One of the most troubling areas is the inability to recognize loved ones and to communicate, which is most prevalent in the final stages of the disease. Because of the difficulty communicating with the AD patient, caregivers are often left with the inability to understand the needs and desires of the AD care-receiver. The AD patient most likely will not be able to say good-bye to the caregiver and this lack of closure can contribute to the caregiver's experience of complicated grief. An important part of the process of resolving unfinished business with the care-receiver is self-forgiveness. Self-forgiveness has been described as "fostering compassion, generosity, and love toward oneself" (Enright, 1996, p. 116).

This study investigated the use of self-forgiveness among caregivers of deceased care-receivers who were diagnosed with AD, and explored the relationship of self-forgiveness with mental well-being. Effective intervention

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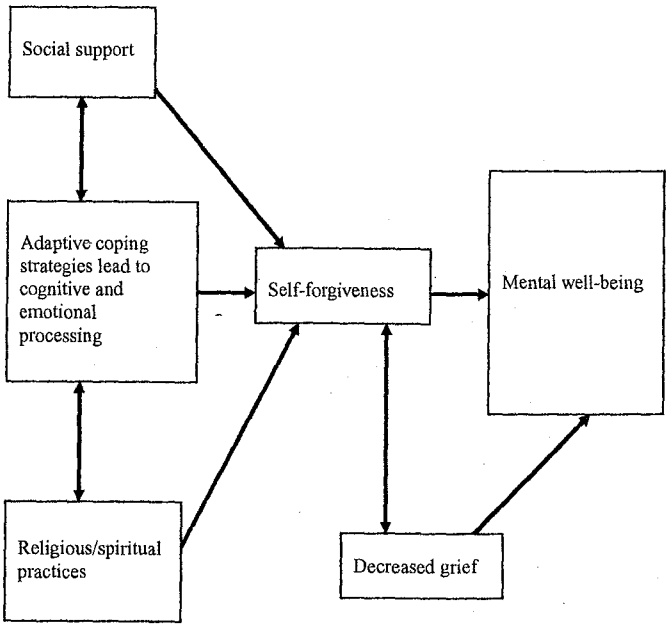
FIGURE 1. Self-Forgiveness Framework



approaches utilizing self-forgiveness can be developed to work with caregivers who are having difficulty progressing through the three grief stages described by Temes (2000): numbness, disorganization, and reorganization. Intervention approaches might include the exploration of adaptive coping strategies, religious/spiritual practices, social support, self-forgiveness, and decreased grief in order to work through the unfinished business caregivers have with care-receivers.

The Self-Forgiveness Framework (Figure 1) reflects the caregiver's journey toward self-forgiveness and includes the following independent variables: adaptive coping, religious/spiritual practice, and social support. The outcome variables are decreased grief and mental well-being, and the mediating variable was self-forgiveness. The Self-Forgiveness Framework explores the relationship between the following variables and self-forgiveness: social support, adaptive coping, and religious/spiritual practice. This study seeks to further explore the relationship between decreased grief and self-forgiveness as well as the relationship between mental well-being and the variables decreased grief and self-forgiveness.

LITERATURE REVIEW

The literature about caregivers negotiating self-forgiveness after the death of a care-receiver is lacking, however there is increasing research around the topic of forgiveness and self-forgiveness with other populations. A review of the literature on self-forgiveness revealed approximately 46 peer-reviewed articles on the topic, none of which focused on caregivers working through self-forgiveness after the death of a care-receiver diagnosed with AD.

Although the study of self-forgiveness developed in the 1990s, the study of forgiveness has a longer history. For centuries forgiveness was the focus of religious teachings, but the scientific study of forgiveness is a recent phenomenon that began in the 1970s (Rokeach, 1973; Shoemaker & Bolt, 1977). Self-forgiveness emerged as a way of understanding how individuals work through their own grievances with themselves (Flanagan, 1996; Luskin, 2000; Rutledge, 1977). Prior to 1985 there were five published studies that explored forgiveness (Worthington, 1998): Brown (1968); Zillman, Bryant, Cantor, and Day (1975); Zillman and Cantor (1976); Axelrod (1980); and Darby and Schlenker

(1982). Smedes (1984) wrote a book on forgiveness that captivated the general public and gained the attention of mental health professionals (Worthington, 1998). Forgiveness and the process by which individuals move from unforgiveness to forgiveness of others and of self were key concepts in Smedes work. Caregivers who provide long-term care for a care-receiver experience many events during the caregiving period. These events may contribute to self-forgiveness as part of the grieving process for the caregiver after the death of a care-receiver. This review will consider the relationship of self-forgiveness and adaptive coping, social support, religious/spiritual practice, grief, and mental well-being.

This study focuses on the relationship between adaptive coping and self-forgiveness. Willis, Blechman, and McNamara (1996) reported on coping strategies in response to stress-producing situations. Aspinwall and Taylor (1997) and Schwarzer and Knoll (2003) examined anticipatory coping response to future stressors. Fisher and Exline (2006) in a study of 138 undergraduate students reported that an absence of self-condemning attitudes was an indicator of self-forgiveness and acceptance of responsibility for one's behavior, if paired with a sense that self-forgiveness requires effort, will predict a prosocial response.

Additionally, this study posits a relationship between religious/spiritual practice and self-forgiveness. Toussaint and Williams (2008) in a study of Protestant, Catholic, and nonreligious groups reported that self-forgiveness did not result among those who reported higher levels of feeling forgiven by God. Tangney, Boone, and Dearing (2005) reported that there was no difference in self-forgiveness by religious affiliation. Tangney and colleagues observed that self-forgiveness is confounded with the feelings of shame and guilt. Shame and guilt are emotions that are likely to be experienced by both Christians and non-Christians following an offense. Enright and the Human Development Study Group (1996) observed that self-forgiveness is difficult for two reasons: (a) the abstract concepts of self-compassion and reconciliation are cognitively challenging for most people, and (b) many Christians may feel higher levels of forgiveness from God and others but still may not be any more forgiving of themselves than nonreligious people.

Wohl, DeShea, and Wahkinney (2008) reported that when a person is able to self-forgive, her or his feelings, actions, and beliefs about the self become more positive with the person likely to not attribute negative qualities to the self. Self-forgiveness and forgiveness of others may be associated with mental well-being (Fisher & Exline, 2006; McCullough, Pargament, & Thoresen, 2000; Wohl et al., 2008) as well as psychological well-being (Witvliet, Ludwig, & Vander Laan, 2001). Other research suggests that there is a relationship between religion and well-being, hope, and positive coping (Almberg, Grafstrom, & Wineblad, 2000; Campbell, 2002, Koenig, 1999, 2000; Koenig, George, & Siegler, 1988; Pargament, Koenig, & Perez, 2000; Van Hook & Rivera, 2004). Hall and Fincham (2008) in a study of 148 students reported that self-forgiveness increased in a linear manner over time, and the decline in guilt feelings, perception of the level of severity of the transgression, and conciliatory behavior toward a higher power were correlated with increasing self-forgiveness.

This study will also examine the effects of social support on self-forgiveness. Fiore, Becker, and Coppell (1983); Kiecolt-Glaser, Dyer, and Shuttleworth (1988); and Wuest, Ericson, Stern, and Irwin (2000) observed that a lack of social support may leave some caregivers with feelings of isolation and disconnection from resources to support them, from buffers that prevent negative psychological states of mind leading to self-blame, and from feelings of being overwhelmed by the demands of their life circumstances. Additionally Clayburn, Stones, Hadjistavropoulous, and Tukko (2000) concur that a lack of social support has the potential to block daily living strategies that lead to self-forgiveness.

Furthermore, this study will investigate the effects of decreased grief on self-forgiveness. Schultz, O'Brien, Bookwala, and Fleissner (1995) reported that caregivers experienced considerable relief when death was preceded by a long-term stressful period. Walker and Pomeroy (1997) reported that anticipatory grief had a positive impact on post-death grief work.

Finally, this study will use the previous literature for outlining the relationship between self-forgiveness and mental well-being. Ingersoll-Dayton and Krause (2005) studied this concept using 129 individuals age 65 and older and found that in exploring self-forgiveness and mental health, religion was cited as an important part of their lives. The study found that participants' reactions after committing an offensive behavior are especially relevant to caregivers who find that "self-acceptance remains elusive because of feelings of guilt resulting for past transgressions" (p. 267). One technique to address these feelings was a type of life review where the study participants engaged in a review of memories related to experiences and circumstances that have happened throughout the course of their lives. Facing painful memories and working through them were considered essential elements of a life review. Exploring these memories identified how much time was spent ruminating about past experiences with the care-receiver that may have resulted in unfinished business. Therefore, at times, rumination was counterproductive and lead to negative well-being (Ingersoll & Krause, 2005).

In contrast, when studying Christian college students, it has been reported that shame and guilt or behavioral sorrow may actually have a positive role in seeking forgiveness (Bassett et al., 2008). Strelan (2007) reported that guilt maintained a strong correlation with self-forgiveness, and that guilt and self-esteem mediated the relationship between narcissism and self-forgiveness.

Four additional peer-reviewed studies with university students as subjects have implications for the caregivers in this research: (a) a study reporting that self-forgiveness has a powerful impact on self-reported physical and mental health, and that religiosity is not correlated with self-forgiveness (Avery, 2008); (b) a quantitative study exploring the failure to forgive self and others (Maltby, Macaskill, & Day, 2001); (c) a study exploring the motivational underpinnings of self-forgiveness (Ross, 2004); and (d) some of Bowman's (2005) findings were that self-forgiveness and forgiveness of other is related, self-acceptance is required in the experience of self-forgiveness, and the client's prior experience of self-forgiveness is also a contributing factor.

After reviewing the current literature it was found that none of these studies in the area of self-forgiveness related to the population of caregivers of people with AD. Therefore, this study extends the current literature to include the use of self-forgiveness among caregivers of deceased care-receivers who were diagnosed with AD, and subsequently outlines the relationship of self-forgiveness with mental well-being.

Hypothesis 1: A positive relationship exists between self-reports of caregiver adaptive coping and reported levels of caregiver self-forgiveness. The independent variable is the reported level of caregivers' adaptive coping and the dependent variable is the reported level of caregivers' self-forgiveness.

Hypothesis 2: A positive relationship exists between self-reports of caregiver religious and spiritual practices and reported levels of caregiver self-forgiveness. The independent variable is the reported level of caregivers' religious and spiritual practices and the dependent variable is the reported level of caregivers' self-forgiveness.

Hypothesis 3: A positive relationship exists between self-reports of caregivers' level of social support and reported levels of caregivers' self-forgiveness. The independent variable is the reported level of caregivers' social support and the dependent variable is the reported level of caregivers' self-forgiveness.

Hypothesis 4: A positive relationship exists between self-reports of caregivers' level of self-forgiveness and the reported levels of caregivers' decreased grief. The independent variable is the reported level of caregivers' self-forgiveness and the dependent variable is the reported level of caregivers' decreased grief.

Hypothesis 5: A positive relationship exists between self-report of caregivers' mental well-being and reported levels of caregivers' self-forgiveness. The independent variable is the reported level of caregivers' self-forgiveness the dependent variable is

reported levels of caregivers' mental well-being.

METHODOLOGY

Participants

The study sample consisted of 133 participants. The majority of the participants were female (75.9%), White (97.7%), widowed (42.1%), and Protestant (58.6%). The caregiver's relationship to the care-receiver included children (43.6%) or spouses (42.1%). The age of study participants ranged in age from 41 to 91. The largest group of people that caregivers reported receiving social support from were friends (63.6%) followed by daughters (51.2) and medical doctors (51.2%). Of the 133 study participants 5 (3.8%) reported that they had no social support network and 12 (9%) indicated that they had more than 41 individuals in their social support network. The length of time for which caregivers provided care ranged from 6 months to 21 years.

Procedure

After receiving approval for the study through the related Human Subjects Review Board, participants were recruited through hospices and agencies that provide services for AD patients and their caregivers. A survey packet was mailed to participants with a cover letter introducing the researcher, explaining the purpose, and inviting research participation. Participants were asked to complete the survey and return it to the researcher in a self-addressed stamped envelope. No names were gathered and it was explained that by returning the completed survey participants understood that this would indicate informed consent. In addition to completing the five survey instruments, demographic information such as age and race were gathered.

Measures

Self-Forgiveness

A 10-item self-forgiveness measure using a 5-point Likert scale was developed by the researcher for use in this study. Five of the items on the scale were reverse scored. The measure includes questions about whether the caregiver is able to forgive self and the caregiver's perception of her or his affective state after forgiving self. The following is an example of one of the items: "It is easier for me to forgive myself than to forgive others." Because this measure was designed by the researcher, reliability information was computed. The scores ranged from 10 to 50 with higher scores indicating higher levels of self-forgiveness. The Cronbach's alpha for this measure was .75.

Adaptive Coping

The R-COPE (Revised COPE; Zuckerman & Gagne, 2003) was used to measure adaptive coping in this study. This instrument was chosen because of its excellent psychometric properties. The 40-item self-report instrument contains five subscales: Self Help, Approach, Accommodation, Avoidance, and Self-Punishment. The R-COPE uses a 7-point Likert scale ranging from Strongly Agree to Strongly Disagree. The three subscales that appear to address adaptive coping, Self-Help, Approach, and Accommodation, were used in this study. The total scores for the three adaptive coping subscales of the R-COPE ranged from 24 to 168. The following is an example of one of the items: "I take time to express my emotions." The Cronbach's alpha scores reported by Zukerman and Gagne (2003) and this study are reported in Table 1.

Social Support

A search of the literature for social support measures for caregivers of deceased AD care-receivers did not reveal an instrument specifically focused on caregivers' post-death grief work related to the care-receiver. Therefore, a social support instrument was developed for this study that included 12 items designed to measure the participants' perceptions of their level of social support. The 12 items consisted of questions using a 5-point Likert scale with higher scores indicating higher levels of perceived social support. The 12 items included questions about family, friends, support groups, religious affiliation, and health care professionals. The following is an example of one of the items: "I attend a

TABLE 1. Cronbach's Alpha for R-COPE Subscales

	Zukerman & Gagne (2003)			
Subscale	Sample 1	Sample 2	Sample 3	This study
Self-Help	.92	.91	.94	.88
Approach	.87	.88	.83	.89
Accommodation	.82	.88	.83	.87

support group for caregivers while providing care to my loved one." The Cronbach's alpha for this measure was .67.

Decreased Grief

The instrument with excellent psychometric properties that was the best fit for this study was the 50-item Marwitt and Meuser Caregiver Grief Inventory (MM-CGI). The items are answered using a 5-point Likert scale. Marwitt and Meuser (2002) reported that the Cronbach's alpha scores ranged from .90 to .96. Because of the length of the MM-CGI a number of unrelated items were removed from the instrument for use in this study. While the 35 remaining items addressed post-death grief, only three items were further selected for this study. The three items most closely represented Temes's (2000) third stage of grief: reorganization. The scores for the three items ranged from 3 to 15. The Cronbach's alpha for the subscale labeled *reorganization* was .64.

Religious/Spiritual Practices

A two-item measure was developed for this study and the items were coded using a 5-point Likert scale with responses ranging from 2 to 10, with 10 indicating more engagement in religious services or spiritual practices. Because this measure was designed by the researcher, reliability information was computed. The Cronbach's alpha for items 1 and 2 of this measure was .70.

Mental Well-Being

The General Health Questionnaire-5 (GHQ-5; Shamasunder, Sriram, Murali Raj, & Shanmughan, 1986) was selected for this study because of its psychometric properties and fit with the study's focus. The GHQ-5 consists of five items taken from the earlier 60-item GHQ developed by Goldberg (1972) as a self-administered instrument that can be used when working with clients who have a nonpsychotic illness. Participants responded to five items using 0 to reflect the absence of the item and 1 to indicate the presence of the item. An example of an item is: "Have you recently been feeling unhappy and depressed?" The scores ranged from 0 to 5 with lower scores indicating the absence of mental illness. The Cronbach's alpha for this study was .86.

RESULTS

Tests of Hypotheses

Before each of the major hypotheses was tested for possible explanatory power using regression analysis, the relationships were examined at the bivariate level with the following results.

Hypothesis 1

To test Hypothesis 1 ("A positive relationship exists between self-reports of caregiver adaptive coping and reported levels of caregiver self-forgiveness") a Pearson correlation analysis was completed. The results indicated a moderate positive correlation ($r = .536$, $p < .001$) between the two variables. It appears that for this group of participants an increase in caregiver *adaptive coping* is associated with increased levels of *caregiver self-forgiveness,* which supports Hypothesis 1 (see Table 2).

Hypothesis 2

To test Hypothesis 2 ("A positive relationship exists between religious/spiritual practices and reported levels of caregiver self-forgiveness")

TABLE 2. Results of Correlation Analysis Between Self-Forgiveness and Adaptive Coping, Religious Practices, Social Supports, Decreased Grief, and Mental Well-Being ($N = 133$)

Variable	1	2	3	4	5	6
1 Self-forgiveness	1	.536[b]	.255[b]	.395[b]	.506[b]	.375[b]
2 Adaptive coping		1 .202[a]	.256[b]	.373[b]	.385[b]	
3 Religious/spiritual practices			1	.180[a]	.022	.023
4 Social support				1	.077	.175
5 Decreased grief					1	.299
6 Mental well-being						1

[a]Correlation is significant at the 0.05 level (2-tailed test).
[b]Correlation is significant at the 0.01 level (2-tailed test).

a Pearson correlation analysis was completed to determine whether these variables were also correlated. The results from testing this hypothesis indicated that a significant positive correlation ($r = .255$, $p < .001$) existed between *religious/spiritual practices* and levels of caregivers' *self-forgiveness*, which supports Hypothesis 2 (see Table 2).

Hypothesis 3

To test Hypothesis 3 ("A positive relationship exists between caregivers' levels of social support and their levels of caregiver self-forgiveness") a Pearson correlation analysis was computed. The results indicated a moderate positive correlation ($r = .395$, $p < .001$) between the two variables. It appears that for this group of participants, an increase in caregiver *social support* is associated with increased levels of caregiver *self-forgiveness,* which supports Hypothesis 3 (see Table 2).

Hypothesis 4

To test Hypothesis 4 ("A positive relationship exists between caregivers' levels of decreased grief and caregivers' levels of self-forgiveness") a Pearson correlation analysis was completed. The results indicated a moderate correlation ($r = .506$, $p < .001$) between the two variables. It appears that for this group of participants an increase in caregivers' grief coping skills is associated with increased levels of caregivers' *self-forgiveness,* which supports Hypothesis 4 (see Table 2).

Hypothesis 5

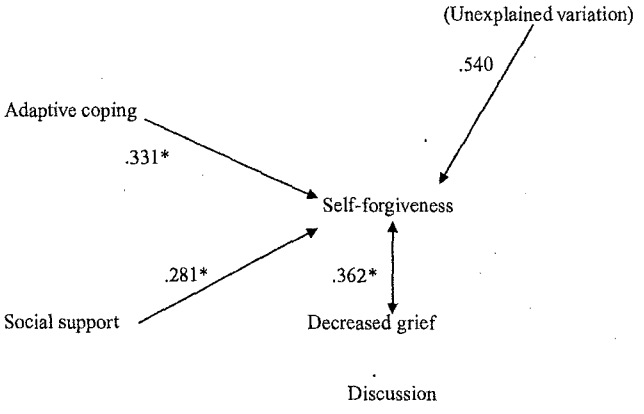
To test Hypothesis 5 ("An inverse relationship exists betweens caregivers' self-forgiveness and reported levels of mental well-being") a Pearson correlation analysis revealed a statistically significant, direct relationship ($r = .375$, $p < .01$) between the two variables. It appears that for this group of participants, a decrease in caregivers' *mental well-being* scores (indicating a person's increased mental well-being) is inversely related to an increase in caregivers' *self-forgiveness,* which supports Hypothesis 5 (see Table 2).

Bivariate and Stepwise Regression Analysis

After testing for the bivariate relationships postulated in the five hypotheses, stepwise regression analysis was computed to explore relationships and to determine which variables might be significant predictors of self-forgiveness. The logic for examining the relationships in the regression models was based on the correlation values found between *adaptive coping* and *self-forgiveness* ($r = .536$, $p < .01$), *religious/spiritual practices* and *self-forgiveness* ($r = .255$, $p < .01$), *social support* and *self-forgiveness* ($r = .395$, $p < .01$), *grief* and *self-forgiveness* ($r = .506$, $p < .01$), and *self-forgiveness* and *mental well-being* ($r = .375$, $p < .01$).

The proposed self-forgiveness framework that was presented in Figure 1 was not supported by the stepwise regression models of this study. The original hypothesized relationships in

FIGURE 2. Revised Self-Forgiveness Framework (Standardized Beta Coefficients)[a].



[a]GHQ-5 (mental well-being) and religious/spiritual practices were not significant contributors to this model.
* $p < .01$ (2-tailed test)

Figure 1 postulated associations between the variables *social support*, *adaptive coping*, and *religious/spiritual practices* and their impact on caregiver *self-forgiveness*. The researcher had reasoned that caregivers who were recipients of social support engaged regularly in religious/spiritual practices, and caregivers who used adaptive coping strategies were most likely able to work through bereavement and grief issues resulting in self-forgiveness. Decreased grief, believed to be an outcome of the grief and self-forgiveness process, would have an association with self-forgiveness and would contribute to mental well-being. It was postulated that self-forgiveness would be found to positively impact mental well-being (see Figure 1). Bivariate statistics indicated a significant moderate association between mental well-being and self-forgiveness.

Figure 2 presents the Revised Self-Forgiveness Framework. Data from the series of stepwise regressions were utilized to examine relationships in the Self-Forgiveness Framework. In the Revised Self-Forgiveness Framework, with self-forgiveness as the dependent variable, the independent variables adaptive coping, decreased grief, and social supports were found to be significantly associated with self-forgiveness.

Stepwise regression models were computed for the variables in the study hypotheses. Self-forgiveness (dependent variable) and all of the independent variables from the five study hypotheses were entered into the equation (Table 3). In Model 1 when adaptive coping was entered into the model a moderate association ($\beta = .538$, $p < .01$) with self-forgiveness resulted. In Model 1 adaptive coping accounted for 28% ($R^2 = .284$) of the variance in self-forgiveness. The unexplained variation in this model was 72%.

When decreased grief ($\beta = .356$, $p < .01$) was entered into the analysis (Model 2), adaptive coping decreased (from $\beta = .538$, $p < .01$ to $\beta = .405$, $p < .01$). Therefore, the decreased beta score for adaptive coping indicates that the influence of decreased grief interacts with the adaptive coping score such that the amounts of the contribution of the self-forgiveness score decreases. While decreased grief resulted in a

TABLE 3. Stepwise Regression on Independent Variables of the Self-Forgiveness Framework With Self-Forgiveness as the Dependent Variable

Independent Variable	Model 1	Model 2	Model 3
Adaptive coping	.538*	.405*	.331*
Decreased grief		.356*	.362*
Social support			.281*
R^2	.284	.389	.460

*$p < .01$ (2-tailed test).

decrease in the variation of adaptive coping on self-forgiveness, the combination of the two variables (adaptive coping and decreased grief) was responsible for 39% ($R^2 = .389$) of the variance in self-forgiveness. The unexplained variation on self-forgiveness in Model 2 decreased by 11%—from 72% in Model 1 to 61% in Model 2. The beta score for adaptive coping conveys a strong positive association between adaptive coping and self-forgiveness scores. This suggests that initially, adaptive coping was thought to explain almost half the existence of self-forgiveness; however, decreased grief also contributed to the feelings of self-forgiveness.

In Model 3 one additional variable, social support, was tested on self-forgiveness. When social support was entered, the amount of contribution of adaptive coping again declined (from $\beta = .405$, $p < .01$ to $\beta = .331$, $p < .01$), and the influence of social support led to an increase in decreased grief (from $\beta = .356$, $p < .01$ to $\beta = .362$, $p < .01$). The power of the effect of adaptive coping on self-forgiveness decreased, while at the same time the influence of decreased grief on self-forgiveness scores increased to $\beta = .362$. These models indicate that something about social support enhances decreased grief. It also means that the initially strong relationship between adaptive coping and self-forgiveness is intertwined with decreased grief and social support. Even so, the combination of adaptive coping, decreased grief, and social support was responsible for 46% ($R^2 = .460$) of the variance on self-forgiveness (Model 3). The variation on self-forgiveness in Model 3 decreased by 7%—from 61% in Model 2 to 54% in Model 3. In each successive model the interaction between the variables improves our understanding of the experience of self-forgiveness. Finally, it should be noted that in this study neither religious/spiritual practices nor mental well-being were found to be significant in the explanation of variation in self-forgiveness and, therefore, have been removed from the Self-Forgiveness Framework.

Based on this analysis a revised Self-Forgiveness Framework was designed that resulted in decreased grief, adaptive coping, and social support being noted as significant in explaining the variation in self-forgiveness. Mental well-being and religious/spiritual practices were not significant "explainers" of self-forgiveness. It is possible that the three predictor variables also interact and work together to help caregivers forgive themselves.

DISCUSSION

The study found support for the five research hypotheses. Hypothesis 1, which examined the relationship between adaptive coping and self-forgiveness, was supported. Adaptive coping had the strongest association with self-forgiveness among the study variables. This suggests that people who report the use of adaptive coping strategies in dealing with the stress of caregiving would more likely report being able to forgive themselves. These findings are similar to Willis and colleagues (1996), who reported on coping strategies in response to stress-producing situations. Tangney and Colleagues (2005) reported that self-forgiveness is confused with feelings of shame and guilt. This suggests that some individuals use nonadaptive coping strategies. In addition, the findings of this study are consistent with the findings of Aspinwall and Taylor (1997) and Schwarzer and Knoll (2003), which examined anticipatory coping responses to future stressors. In this study, those who used adaptive coping strategies while caregiving, in anticipation of the care-receiver's eventual death, appeared to have been able to work through the grief process and arrive at self-forgiveness within a normal post-death bereavement period.

Hypothesis 2, which examined religious/spiritual practice and self-forgiveness, was supported. The results of the Pearson correlation analysis revealed that religious/spiritual practices were positively correlated with self-forgiveness. In the stepwise regression analysis, religious/spiritual practices were not significant contributors to self-forgiveness. It is possible that the way religious/spiritual practices were conceptualized was too limiting (i.e., only asking about frequency of attendance at religious services and frequency of spiritual practice), and the measure may not have been robust enough to allow viable inclusion in the regression analysis. This study appears to concur with Avery (2008), who reported

on the relationship between self-forgiveness and the variables were supported. Therefore, these findings provide strong support to the assertion that the grief process is complicated and individuals will more readily experience decreased grief if they are allowed and encouraged to work through self-forgiveness.

Weaknesses of the Study

The study sample consisted of a nonrandom convenience sample of caregiver participants, and the majority of the respondents were predominantly European American, Christian, and female. With regard to the demographic information, the wording of the demographic items regarding racial/ethnic group membership may have confused some respondents. There is a possibility that the term *Native American* was unclear. Fifteen people identified themselves as Native American, which seems to be a disproportionately large number given the sample population. Some individuals may have marked the category because they were born in the United States. One of the respondents stated that she or he was born in the United States and selected the Native American category to signify racial/ethnic identity. In addition, the study revealed covariance in the Pearson correlation analysis relationships between variables. This suggests overlap between the variables because several of the variables may share some aspects of the same dimension of the human experiences that were being tested in two or more of the measurements. For instance, it could be argued that self-forgiveness is an aspect of adaptive coping and those experiencing decreased grief also demonstrate adaptive coping behavior. The study is also limited in its generalizability to other groups.

CONCLUSION

This study suggests that there are a number of implications for practice with this caregiver population. Inquiring as to whether a caregiver needs to work on self-forgiveness is an important element when addressing bereavement issues. This study points to the importance of recognizing that in working with caregivers, progress can be complicated by issues of shame and guilt and other characterological issues such as coping strategies, ways of looking at life events, and mental health issues.

Based on the results of this study it appears beneficial to caregivers if service providers offer an assessment of the coping skills of caregivers, and, after this assessment, the intervention process focus on assisting individuals to recognize and further develop adaptive coping strategies. Self-forgiveness is also associated with the grief process and overlaps with the task of self-forgiveness. Therefore, interventions that address grief will also benefit from the inclusion of self-forgiveness activities.

Social support was also an important variable that needs to be nurtured because of its relationship toward achieving self-forgiveness. Providing respite opportunities and other social gatherings in support of the caregiver can help the caregiver feel nurtured and focus on themselves in order to survive the caregiving period. Lastly, mental well-being was also associated with self-forgiveness and periodic assessment of mental and physical functioning should be included in work with caregivers during both the caregiving period and the period following the death of the care-receivers.

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