Chapter 15

RELIGION, COPING, AND ADJUSTMENT

When misery is the greatest, God is the closest.

While I am sick, I desire the love of religion.

God helps them that help themselves.

A mighty fortress is our God,
A bulwark never failing;
Our helper He amid the flood
Of mortal ills prevailing.

We turn to God only to obtain the impossible.

A little girl repeating the Twenty-Third Psalm said it this way: "The Lord is my shepherd, that's all I want."[1]

September 11, 2001 posed a huge and unexpected problem with which U.S. residents had to cope. The destruction of the World Trade Center in New York City, and the attack on the Pentagon in Washington, D.C., still reverberate in U.S. society. A war on terrorism was proclaimed, and the nation was immediately put on guard. Air passenger inspections were extensively tightened. The government mobilized a variety of resources for sensitizing the American people to the dangers posed by terrorism. Home preparedness became the watchword. At this writing, the United States continues to be bombarded with alarms and warnings of possible new attacks from enemies. How have people dealt with these changes?

In the week following the September 11 tragedy, U.S. national polling organizations reported anywhere from a 6% to a 24% increase in church attendance (Walsh, 2002). This trend continued through October into November. Members of many religious bodies sensed a revival of faith. People were turning to their deity for support and comfort. *The Boston Globe* reported that religious education programs were stimulated by "many of these new, terrorism-inspired seekers" (quoted in Walsh, 2002, p. 27). Was this indeed a new revival of faith? Apparently not, as 3 months later, the influx of churchgoers had receded to pre-September 11 levels. Coping by means of religion had subsided. Does this imply that religious coping is little more than a "passing fancy"? Even though we must await more definitive studies of who was affected by the September 11 disaster and how personal resources were marshaled, let

1. These quotations come, respectively, from the following sources: Gross (1982, p. 242); Theobaldus, quoted in Benham (1927, p. 843); Benjamin Franklin, quoted in Bartlett (1955, p. 330); Martin Luther, quoted in Bartlett (1955, p. 86); Albert Camus, quoted in Peter (1977, p. 213); Mead (1965, p. 166).

us examine the fact that religion often serves as a major bulwark in the way we handle the stress of living.

Coping is at the heart of life. From its biological and evolutionary roots to complex human social behavior, it is the essence of living. In individualistically oriented Western society in particular, people are usually judged on their ability to cope with what is demanded of them. In many cases, personal trials prompt people to turn to their faith for help. Religion may be an especially important resource when individuals must deal with those "times that try men's souls"—when crisis strikes and options are limited.

THEORETICAL APPROACHES TO COPING AND RELIGION

"Coping" means resolving the difficulties that confront us as human beings. This can be done in any of three ways—changing the environment, changing ourselves, or changing both to some degree. "Adaptation" involves the second or third possibility; "adjustment" more strictly implies self-modification to meet situation requirements.

In order to understand how people handle life's problems, some researchers have emphasized coping *styles* or *traits*—relatively long-lasting, if not permanent, characteristics of individuals. Others have looked to the *process* of coping, and to change in the way difficulties are handled (Lazarus & Folkman, 1984). Though it may be argued that personal religiosity is commonly treated as if it were an aspect of personality, those who have studied the role of religion in coping are mostly concerned with it as a process variable, asking what it does for the person and how it functions when problems arise.

The Process of Coping: Pargament's Theory

Probably the foremost scholar in research on the role of faith in relation to coping behavior is Kenneth Pargament of Bowling Green State University. For a number of years, he has been meticulously defining and assessing the contributions of religion to the various facets of the coping process. His book *The Psychology of Religion and Coping* (Pargament, 1997) is the definitive work in the field. With a colleague, he has asserted:

> People do not face stressful situations without resources. They rely on a system of beliefs, practices, and relationships which affects how they deal with difficult situations. In the coping process, this orienting system is translated into concrete situation-specific appraisals, activities, and goals. Religion is part of this general orienting system. A person with a strong religious faith who suffers a disabling injury, must find a way to move from the generalities of belief to the specifics of dealing with the injury. (Silverman & Pargament, 1990, p. 2)

Building upon the work of Lazarus and Folkman (1984), Pargament (1997) identifies the initial step in the coping process as "appraisal." First, when an event takes place, the person implicitly asks, "What does this mean to me?" In other words, is it irrelevant, positive, or negative? If the answer is that it is negative and stressful, the next question becomes "What can I do about it?" This brings to the fore additional judgments of "harm/loss," "threat," or "challenge." In the case of harm/loss, the individual has already suffered some adverse effects, such as illness or injury. Threat focuses on anticipated difficulties, whereas in challenge the person sees the likelihood of future growth and development. This form of appraisal has

also been termed "primary appraisal." Pargament notes the differential role of religion in such appraisal, as a person can view what is happening as an intentional action of God to teach a lesson, or possibly to reward or punish via everyday success or failure.

The apparent clarity of the challenge, harm/loss, and threat conceptualization has not resulted in consistent findings, however. Two studies found that religious coping was more likely to be employed in threat and harm/loss situations than in challenge ones (Bjorck & Cohen, 1993; Bjorck & Klewicki, 1997). McRae (1984) observed that of 28 coping possibilities, religion ranked 2nd when harm/loss occurred to others, but only 13th when it was personally experienced. Faith came in 2nd and 7th, respectively, for threat to others and to the self; it ranked 14th and 10th, respectively, for other-directed and self-directed challenge situations. Though the findings of Bjorck and colleagues and of McRae imply that responses are state- rather than trait-dependent, Maynard, Gorsuch, and Bjorck (2001) failed to find any differences among the three stressor scenarios, suggesting that traits are also part of religious coping behavior. An interesting alternative that might be introduced into this area is to assess the degree of ambiguity and self-doubt in the respondent for each of these stress possibilities. Moreover, instead of utilizing religion as a means of coping, a person under stress might turn to materialistic possibilities (Chang & Arkin, 1999). More research is obviously needed to resolve these questions.

Dealing with the problem is the next step in the coping process, and the act of deciding how to do this has been labeled "secondary appraisal." In secondary appraisal, an assessment of personal resources for dealing with the difficulty occurs. A religious person may do a number of things, one of which is praying—a behavior that Holahan and Moos (1987) view as an active, cognitive coping strategy. The praying person is doing something, making an appeal to the highest power possible for help in overcoming misfortune and suffering. This may be constructive, in that it can spur the individual to adopt new means to solve a problem. Prayer, however, may also be dysfunctional if it causes the person to avoid actively seeking to confront the predicament by trusting passively in God to solve the dilemma.

When people assess ways of dealing with various difficulties, they face two obstacles: the problem itself, and the emotions that the problem arouses. Chances are that both will be dealt with, but to different degrees. Attention is initially directed more toward one of these concerns than the other, suggesting that an individual's style of coping may be primarily "problem-focused" or "emotion-focused" (Lazarus & Folkman, 1984). Moreover, the person may deal with the problem by using either "approach" or "avoidance" strategies, and the latter can be indicative of poor adjustment to the situation. Though emotion-focused coping may be beneficial and may manage anxiety constructively (i.e., it may be a form of "approach", the general tendency has been to regard this concern as largely avoiding the problem (Holahan & Moos, 1987). We sometimes see this emotion-focused avoidance when life is especially trying, as among elderly persons who are ill (Conway, 1985–1986). Whether or not religion is distracting under such circumstances, it does seem to stress the reduction of unpleasant emotions first.

Evidence suggests that people are likely to use problem-focused cognitions and behaviors when a situation is considered changeable. If circumstances can't be modified, the tendency is to resort to emotion-focused coping. Those who turn to prayer and religious methods frequently consider the problems toward which these means are directed as changeable. At the same time, particularly among younger people, religion may counter undesir-

able emotions (disgust and anger) while enhancing pleasure and happiness (Folkman & Lazarus, 1988). In other words, turning to one's faith in times of difficulty is helpful and constructive in dealing with both problems and emotions.

Pargament (1997) caps his theory of coping with the notion that people engaged in coping are gaining or searching for a "sense of significance" (p. 92). This is especially cogent for a theory that emphasizes religious coping, since religion is an exclusively human venture. "Significance" is really a complex composite of values, beliefs, feelings, and conceptual schemas that defines the phenomenological essence of a person. Significance is thus a unified, holistic pattern of orientations toward oneself, others, and the world. Pargament (1997) also speaks of an "orienting system, a frame of reference, a blueprint of oneself and the world that is used to anticipate and come to terms with life's events" (p. 100). It therefore contributes to and is part of the search for significance. Needless to say, religion, for many if not most people, is an important part of this orienting system. Given the detailed nature of his perspective, it is understandable how Pargament has been able to carry on an extensive research program on religion and coping.

The Coping Functions of Religion

In our view, stress, whether it involves harm/loss, threat, or challenge, reflects a situation in which meaning and control are in jeopardy. We may have difficulty making sense out of a situation, or be unable to master it. Religion is one way these needs are met, and the worldwide prevalence of religion may testify in part to the success of faith in attaining these goals. In Chapters 1 through 3, we have offered a framework for conceptualizing the psychology of religion in terms of meaning and control. We now further enlarge the scope of this framework, in order to understand the functions of religion for coping with life.

The Need for Meaning

Baumeister (1991) simply and directly tells us that religious meanings help people cope with the trials of life. Like Lazarus and Folkman (1984), he views meaningful explanations as helping to solve problems and regulate emotions. Similarly, Fichter (1981) asserts that "religious reality is the only way to make sense out of pain and suffering" (p. 20). That this struggle to understand tragedy via religion may last for a long time is evidenced by one extensive study (Echterling, 1993). Interviews with flood disaster survivors over a 7-year period led the researcher to infer that "they became theologians by asking how God could have allowed such tragedies to occur to them and their loved ones. They became philosophers by asking the meaning of life when they knew how frail and ephemeral life could be" (Echterling, 1993, p. 5). In other words, they searched for meaning in their moment of trial.

Simply put, being able to comprehend tragedy—to make it meaningful—probably constitutes the core of successful coping and adjustment. For most people, religion performs this role quite well, especially in times of personal crisis.

Faith habitually conveys the meaning that life's difficulties can be overcome. Whether or not people control objective conditions may be less important than their belief that even insurmountable obstacles can be mastered. As noted in earlier chapters, in much of life the sense of control is really an illusion; yet it is one that can be a powerful force supporting constructive coping behavior (Lefcourt, 1973).

The Importance of Control

When we apply our framework to religious coping, we find that the concept of "control" takes on new dimensions. These, of course, enrich our theory's structure: They make it more applicable to religion, and they enhance our understanding of the importance of control in human life.

With regard to control and religious coping, Pargament (1997) has posited three approaches that he began researching in 1988, and that have proven quite useful. If a "deferring" mode of relationship is adopted—for example, praying in order to put the problem totally in the hands of God—this does not appear to be as helpful as when a "collaborative" mode of relationship is manifested, in which God and the supplicant work together. Here prayer may keep the individual working on the problem while seeking the support of the deity. In a "self-directive" approach, God is acknowledged, but the problem is regarded as requiring personal rather than divine solution. Gorsuch and his colleagues have proposed a fourth style, which they term "surrender" (Maynard et al., 2001; Wong-MacDonald & Gorsuch, 1997). This is similar to the deferring approach, but the deferring mode is akin to assigning *all* control to the external power of God, whereas the surrender style occupies a middle ground (some or most personal control is "surrendered" to God. In both self-direction and collaboration, by contrast, internal control is present. Petitioning for aid from God (i.e., the collaborative approach) is best for the individual who feels that personal responsibility cannot be deferred or surrendered.

A considerable research literature indicates that for adaptation and coping, an internal locus of control is better than an external locus of control (Phares, 1976). In Pargament's scheme, the self-directive and collaborative coping modes are more internally oriented than the deferring, which is clearly external. On the average, the collaborative and self-directive modes relate to more positive coping outcomes than does the deferring approach (Harris, Spilka, & Emrick, 1990; McIntosh & Spilka, 1990; Pargament et al., 1988).

Coping and Forms of Control. The idea of control is complex—so complex that Skinner (1996) was able to identify 88 control constructs. There is great overlap among these concepts, but one elemental scheme that is pertinent to our concern speaks of two basic forms: (1) "primary control," or "being in charge" (i.e., having the ability to change the situation); and (2) "secondary control," or being able to effect change in oneself. The famous writer Nikos Kazantzakis (1961) noted this latter potential when he quoted a mystic's prescription: "Since we cannot change reality, let us change the eyes which see reality" (p. 45). Faith may play an important role in stimulating both primary and secondary forms of control, and the two forms are probably not independent of each other. In psychological circles, however, religion is largely regarded as functioning as a form of secondary control.

Meaning as Control. In most cases, information gives people the feeling that we can do something about whatever is troubling them. As Sir Francis Bacon put it, "knowledge is power" (quoted in Bartlett, 1955, p. 118). Baumeister (1991) adds that "meaning is used to predict and control the environment" (p. 183), and religious meaning can help people regulate their emotions. In other words, simply having information may reduce stress (Andrew, 1970). A wonderful anecdotal example of how religion can realize this role was provided by a patient with breast cancer, who stated, "I had no idea that God could answer so many of

my questions" (Johnson & Spilka, 1988, p. 12). Though we may call this "informational" control, it is intimately tied to three forms of secondary control that have been theorized by Rothbaum, Weisz, and Snyder (1982). These are termed "interpretive," "predictive," and "vicarious" control, and are especially significant for understanding how religion helps people deal with the problems they confront both in everyday living and in troubled times.

Interpretive Control. When people are in great difficulty, it is natural for them to feel that there is no way out of their predicament. In seeking to understand such an event and to achieve some degree of control over what seems hopeless, people often reinterpret what is taking place. They exercise interpretive control and construe a distressing situation in less troubling or even positive terms. For example, they may claim that "things could be worse" or that "I have it better than a lot of other people." For example, in one study a patient with cancer concluded, "I looked upon cancer as a detour in the road, but not a roadblock" (Johnson & Spilka, 1988, p. 13). Through such interpretations, people gain control over their emotions and may thus become better able to handle their difficulties in a constructive way. In other words, they may become increasingly problem-focused.

Predictive Control. The perpetual human dream is to foretell the future. The idea of precognition fascinates people. If they could predict what would happen on future rolls of dice, who would win horse races, what the stock market might do, or whether their efforts in general would result in success or failure, they would expect to become the beneficiaries of unlimited wealth and happiness. The Bible has said that "The Lord himself shall give you a sign" (Isaiah 7:14).

Predictive control, as a form of secondary control, assures a person that things will turn out all right in the end. For example, another patient with cancer stated, "Because of my relationship with God, I had faith that this cancer was not going to take my life" (Johnson & Spilka, 1988, p. 12). There is a poignant example of predictive control in Eliach's *Chassidic Tales of the Holocaust* (1982). Eliach tells the story of a devout Jew who during World War II was brought by the Nazis into the death camp at Auschwitz. The number 145053 was tattooed on his arm. He looked at it and suddenly concluded that he would live. He reached this conclusion by adding the digits together and finding that they totaled 18; 18 is a number that within Judaism means life, and thus he felt assured of survival. It was as if God had offered an omen signifying a secure future. Such predictive control gives the person confidence that the morrow will be good. We must keep in mind, however, that the critical element here is *perception* of the future; what actually occurs is independent of this aspiration.

Vicarious Control. When people feel that they may not be able to cope with their troubles—particularly in cases of serious illness, where death is a possibility—they often turn to their God, and vicariously, the deity becomes a support or substitute for their own efforts. The essence of such vicarious control was stated by one woman with cancer, who declared, "I could talk to my God and ask for his help in healing" (Johnson & Spilka, 1988, p. 12). Identifying with her God gave her the strength to face potential death through her perceived divine connection. She thus attained a measure of vicarious control over her circumstances.

To illustrate the role of control in relation to faith and coping with health problems, Research Box 15.1 presents a significant study.

Research Box 15.1. Religion and Physical Health (McIntosh & Spilka, 1990)

Treating religion and control as multidimensional constructs, the authors hoped to objectify a primarily anecdotal literature. To accomplish this, they administered a number of questionnaires to 69 college students and 7 adult church members.

Religious orientation was assessed with the Allport–Ross (1967) Intrinsic and Extrinsic scales, and with a revised version of the Quest measure (Batson & Ventis, 1982). In addition, a brief, highly reliable Meaning from Religion scale was developed. Frequency of prayer was also determined.

Control was evaluated by the Levenson (1973) and Kopplin (1976) questionnaires. These yielded scores for internal control, control by chance, control by powerful others, and control by God. The first three constructs were also assessed specifically in relation to health via a measure created by Wallston, Wallston, and DeVillis (1978). Finally, a measure assessing Pargament's "collaborative" mode of relationship with the deity (active person, active God) was also utilized.

The participants' health was evaluated via two measures: (1) health habits (an 8-item checklist), and (2) health status (a 57-item symptom checklist). A factor analysis of the symptom list resulted in four subscales: Emotional, Somatic, Visceral, and Respiratory. These labels indicate the symptomatic content of the measures.

Though considerable statistical significance was observed among the measures, the relationships tended to be weak. The indices of traditional religious commitment (e.g., the Intrinsic scale, the Meaning from Religion scale, the frequency of praying) were associated with better health, whereas Extrinsic scale scores were correlated with signs of poorer health status. With regard to health and control, the external forms of control (chance, powerful others) were found to be related positively to a few indicators of poorer health. The religion scales can be considered aspects of secondary control that reflect coping with stress. Since Intrinsic scale scores were correlated positively with control by God plus a collaborative God–person approach, and negatively with the external forms of control, this suggests further evidence of secondary control. In other words, religion as secondary control beneficially affects health.

What Factors Prompt People to Turn to Religion?

The availability hypothesis or heuristic raises the question of why, in specific circumstances, certain things have a higher likelihood than others of coming to people's minds (Fiske & Taylor, 1991). Among the many factors that might stimulate the selection of religion as a means of coping, the fact that mainstream North American culture and child-rearing practices inculcate a readiness to turn to religion or exercise spirituality in times of distress is undoubtedly the most important. A less obvious point is that religious cues in the immediate situation are apt to be significant. For example, one often sees people (especially in the United States) wearing religious medals, crucifixes, Stars of David, and the like. St. Christopher medals frequently hang from rearview mirrors in cars. Catholics may carry rosary beads with them. Small Bibles are not uncommon. The meaning of such symbols has been nicely demonstrated in one investigation (Antkowiak & Ozorak, 2000). These researchers studied the use of sacred "objects

as means of comfort" (p. 1), and confirmed Lamothe's (1998) view that these objects "not only provide comfort and solace but a sense of identity and cohesion" (quoted in Antkowiak & Ozorak, 2000, p. 7). Such referents may go far toward arousing religious and spiritual thoughts and feelings that calm, refresh, and strengthen distressed individuals.

People also turn to religion because it works for them. Levin and Schiller (1987) raise the interesting possibility that "perhaps the nervous system represents the locus of a mechanism by which religious faith or religious beliefs . . . promote well-being" (p. 24). The mechanism may well be the sense of control that is often promoted by religion (McIntosh, Kojetin, & Spilka, 1985). Specifically, the perceptions that one is personally in control of life situations and that God is in overall control (i.e., Pargament's "collaborative" mode) relate to good health (Loewenthal & Cornwall, 1993; McIntosh & Spilka, 1990). Another possibility has been advanced by Benson (1975)—namely, that certain religious rituals (prayer, meditation, etc.) may stimulate a "relaxation response" that is broadly healthful (Goleman, 1984). In other words, not only may religion promote an increased sense of control; its rituals themselves may reduce stress and tension.

Finally, Bjorck and Cohen (1993) claim that the greater the stress, the more religious coping takes place. Further threats (defined as the anticipation of more damage) elicit greater use of religion than actual harm/losses, which require acceptance. Since events that challenge people call upon personal effort and resources, they are seen as most controllable. Resort to faith as a coping aid is thus least often employed in these situations (Bjorck & Cohen, 1993).

Varieties of Religious Coping

Religion provides many possible ways of coping with the stresses of life. Table 15.1 mainly includes the work of Pargament, Poloma, and Tarakeshwar (2001), yet permits a consideration of various religious devices and roles.

Pargament et al.'s (2001) approach is one way in which the various coping functions may be described. Others may see many of these devices as aspects of prayer, such as confession, thanksgiving, pleading, meditation, or self-improvement (David, Ladd, & Spilka, 1992; see also the discussion of prayer below). An excellent example of coping research in this tradition is presented in Research Box 15.2.

Unhappily, translating concepts into their operational equivalents often runs into difficulty. Pargament, Koenig, and Perez (2000) attempted to develop a comprehensive measure of religious coping. This resulted in seven "negative religious coping scales" and nine "positive religious coping scales." Direct overlap with the varieties of religious coping listed in Table 15.1 appeared to be present in six of the measures. The other notions might have been included in the remaining scales, but were not definitive enough to be distinguished in the respondents' answers to the various questions. This is a very common problem in scale construction.

PRAYER AND FORGIVENESS AS COPING METHODS

Among the many ways religion can be used in coping, two merit special recognition—namely, prayer, because it occupies such a central and significant role in the lives of most people; and forgiveness, which has only very recently been recognized as an important coping mechanism. Interest and research in both realms have been increasing rapidly and cannot be overlooked.

TABLE 15.1. Various Means of Using Religion for Coping with the Stresses of Life

Variety of coping	Typical statement
Self-directive coping	"It's my problem to solve, not God's."
Collaborative coping	"God helps those who help themselves."
Deferring coping	"It's in God's hands."
Pleading religious coping	"Please, God, help me through this terrible time."
Benevolent religious reappraisal	"God gives me these trials to test me."
Punishing God reappraisal	"I have sinned and deserve to suffer."
Demonic reappraisal	"It is the work of the Devil."
Reappraisal of God's powers	"Nothing is too small for God not to notice and help."
Seeking spiritual support	"I know I can rely on God's love."
Spiritual discontent	"How could God do this to me?"
Seeking congregational support	"I know I can depend on my minister and other church members for help."
Interpersonal religious discontent	"I feel as if the church has deserted me."
Religious forgiving	"Father, help me be a better person; let me not be angry and afraid."
Rites of passage	"Now I am a man."
Religious conversion	"I have seen the light; I have found the way; I am born again."

Note. Adapted from Pargament, Poloma, and Tarakeshwar (2001, Table 13.1). Copyright 2001 by Oxford University Press. Adapted by permission.

Prayer

Prayer has often been viewed as the core of faith (Brown, 1994; Buttrick, 1942; Heiler, 1932). It is easy to perform, intensely personal, can be kept private, and is widely employed. Approximately 90% of U.S. residents indicate that they pray, and 76% regard it as very important in everyday life (McCullough & Larson, 1999; Poloma & Gallup, 1991). As Trier and Shupe (1991) have observed, "prayer [is] the most often practiced form of religiosity" (p. 354). We suggest that it is so popular because of how well it helps people cope with their problems.

Religious activities, especially prayer, are usually regarded as positive coping devices directed toward both solving problems and facilitating personal growth (Folkman, Lazarus, Dunkel-Schetter, De Longis, & Gruen, 1986). Some psychologists, however, see religious ritual, including prayer, as a means of controlling one's emotions (Koenig, George, & Siegler, 1988). Others see it as an effective problem-focused mechanism, in that praying may be the only practical way of dealing with many tragedies, such as the death of a loved one (Bjorck & Cohen, 1993). Apparently, it can perform both problem- and emotion-focused functions (Carver, Scheier, & Pozo, 1992).

Forms of Prayer

This simple concept and word, "prayer," covers many possibilities. Foster (1992) conceptually identified 21 different forms of prayer. A survey of seven empirical efforts resulted in from four to nine kinds of prayer (Ladd & Spilka, 2002). The most stable types identified

Research Box 15.2. God Help Me: I. Coping Efforts as Predictors of the Outcomes to Significant Negative Life Events (Pargament et al., 1990)

In this landmark research, a very basic question was addressed: "What kinds of religious coping are helpful, harmful, or irrelevant to people dealing with significant negative events?" (p. 798). The authors also attempted to find out whether measures of religious coping techniques would predict outcomes of coping better than measures of nonreligious coping techniques.

A sample of 586 Christian church members responded to questionnaires assessing religious and nonreligious coping activities and outcomes in regard to negative events that they had experienced during the preceding year. Six kinds of religious coping and four kinds of nonreligious coping were identified. Three outcome measures were assessed: mental health status, general outcome of the negative event, and its religious outcome. The religious variables, to varying degrees, predicted all three of the outcomes. This was most evident for spiritually based activities and for faith and trust in God. Religious discontent and concern with punishment from God hindered coping and adjustment. Positive effects were predictable from perceptions of a just, loving, and supportive deity; involvement in religious rituals, such as attendance at services; prayer; Bible reading; focusing on the afterlife, living a good life; and having support from clergy and church members. It was also observed that an extrinsic, utilitarian faith was helpful. The authors concluded that at least among church members, religious coping is an important and beneficial part of the overall process of coping with stress.

have been "petitionary," "ritualistic," "meditational," "confessional," "thanksgiving," "intercessory," "self-improvement," and "habitual." All have been confirmed and measured by separate, reliable scales (David et al., 1992). One U.S. national study discussed "contemplative," "conversational," "colloquial," "ritual," "petitionary," and "meditative" prayers (Poloma & Gallup, 1991). There is considerable overlap among the various proposed schemes—a condition that has not been helped by the lack of a coordinating theory. If any generalities may be inferred from the data on prayer, it would appear that the more people pray, the more forms of prayer they utilize (David et al., 1992). In addition, frequency of prayer goes with praying for more things—health, interpersonal concerns, and financial matters (Trier & Shupe, 1991).

In order to provide some theoretical footing for conceptualizing prayer, Ladd and Spilka (2002) surveyed the literature and attempted to create a categorizing structure for the forms of prayer that have been empirically identified. This work is detailed in Research Box 15.3.

Usage and Efficacy of Different Forms of Prayer

People are selective in their praying, and the different forms of prayer they use may be employed in different circumstances. For example, patients who have survived more than 5 years since an initial diagnosis of breast cancer are likely to stress prayers of thanksgiving (Ladd, Milmoe, & Spilka, 1994). Petitionary prayers, which are said to be the oldest and most common prayers, are employed to counter frustration and threat, whereas contemplative prayers

Research Box 15.3. Inward, Outward, and Upward: Cognitive Aspects of Prayer (Ladd & Spilka, 2002)

Using the framework suggested by Foster (1992), these researchers first hypothesized that all specific kinds of prayer derive from one underlying basic general factor—namely, a connection between the person who is praying and the deity toward which the prayer is directed. The first level above this underlying factor suggests three main types of prayer. "Inward" prayers are simple, spontaneous, uncensored efforts to connect with the divine. In a sense, the person "bares the soul" and desires to grow. "Outward" prayers shift to the world and needs to be satisfied from outside the person. Here are petitionary and intercessory prayers, hopes to enhance interpersonal relations, and wishes to transform external forces. "Upward" prayers recognize the superior position of God and the inferior status of people. This recognitioni results in meditation, contemplation, adoration, and thanksgiving as possible efforts to experience the divine.

The initial factor analysis, utilizing 309 responders to 153 items, resulted in eight factors. These item composites distinguished a number of inward, outward, and upward forms of prayer.

A second-order factor analysis of the first-order factors was undertaken. Three factors resulted, one of which was clearly composed of outward prayer content; however, the other two combined inward and outward, and inward and upward, possibilities. Even though the first-order factors revealed the three theorized prayer directions, these became mixed in the second-order analysis.

A final, third-order factor analysis did not result in the hoped-for general factor. One wonders whether the three hypothesized directions might be better delineated with a larger sample and a more careful selection of test items. Even though this research was not fully successful, theoretically guided work like this opens the door to more refined and systematic thinking and work in the realm of prayer.

(attempts to relate deeply to one's God) seem to aid internal integration of the self (Janssen, de Hart, & den Draak, 1989; Poloma & Gallup, 1991). Meditational prayers (which are concerned with one's relationship to God) seem to reduce anger, to lessen anxiety, and to aid relaxation (Carlson, Bacaseta, & Simanton, 1988). Contemplative prayers have also been shown to aid psychotherapy by lessening distress and specific kinds of complaints (Finney & Malony, 1985a). By contrast, there is some suggestion that mechanical, ritualized prayers may relate negatively to well-being (McCullough & Larson, 1999).

Little coping research has been done with most forms of prayer; however, a few, such as intercessory and petititionary prayer, are deserving of further exploration.

Intercessory Prayer. Intercessory prayer is a particularly controversial issue. The idea that prayers in behalf of another person can influence the health of that other person has a long history. It has been subjected to research, but this generally leaves much to be desired.

In 1965, Joyce and Weldon matched patients with chronic or progressively deteriorating rheumatic or psychological illness on gender, age, and clinical diagnosis. Two groups of

19 patients each were created. The "treatment" group participants were prayed for by members of a prayer group. The "nontreatment" group served as a control. Each patient in the "treatment" group was the recipient of a total of 15 hours of prayer over a 6-month period. This was a double-blind study in which neither the patients nor their physicians knew of the prayer "treatment." After 6 months of intercessory prayer, no differences between the two groups could be demonstrated.

Within a few years, another intercessory prayer study was reported by Colipp (1969). This involved 18 children with leukemia, 10 of whom were randomly chosen to be the objects of prayer by the author's friends and church members. After 15 months of prayer, the treatment group seemed to have a slight advantage over the control group in survival at the 10% level of confidence.

More recently, an attempt was made to see whether intercessory prayer might favorably reduce alcohol consumption by individuals with alcohol abuse or dependence. A control/comparison group was employed, but after 6 months, no differences between the groups were observed (Walker, Tonigan, Miller, Comer, & Kahlich, 1997).

McCullough and Larson (1999) cite an unusual finding in a study comparing the "agents" of prayer (those who request God's intercession) with the "subjects" (those needing God's intervention). That is, the agents revealed greater improvements in their mental state than did the subjects for whom intercessory prayers were offered.

A fourth study utilizing 393 patients with coronary disease was undertaken by Byrd (1988). Patients, doctors, and the author were all kept "blind" (i.e., unaware of which patients were assigned to which conditions) in this work. The results seemed to support the power of intercessory prayer, as the treatment group appeared to do better than the controls. Though this work looks impressive on the surface, many serious questions may be posed regarding its design, the data analysis, the results, and their interpretation. In fact, strong challenges to virtually all of these studies can be advanced, based on the nature (and often size) of the samples, evaluation procedures, methodology, and statistical analyses. If scientific doubts are not enough, many theologians should be able to mount their own criticisms of this kind of work. We must conclude that at this stage of research on intercessory prayer, its power and significance have yet to be demonstrated.

Petitionary Prayer. As noted above, petitionary prayer is the most common kind of prayer offered, and though it is often treated negatively by religionists, it has repeatedly been averred that "petition is the heart of prayer" (Capps, 1982, p. 130). Capps (1982) further terms it "the crux of the psychology of religion" (p. 131). Simply said, prayers of petition ask for something. One content analysis of 227 petitionary prayers (Brown, 1994) showed that most requested something for family members (37%); next came prayers for alleviation of illness (21%). (The latter, though petitionary, were also intercessory when the illness was that of someone else, not the person doing the praying.) In third place were petitionary prayers for persons who had died (Brown, 1994). Obviously, people can plead for anything—one reason for the popularity of petitionary prayers. Earlier work by Brown (1966) with children and adolescents led to the conclusion that on the average, the more serious a situation is, the more strongly young people feel petitionary prayer is appropriate. An egocentric belief in the direct efficacy of petitionary prayer decreases with increasing age. There is reason to believe that as the belief in the material effectiveness of these prayers lessens, it is replaced by a belief in nonspecific effects, such as "granting courage, improving morale or producing other psychological changes" (Brown, 1968, p. 77).

Forgiveness

Even though the theme of forgiveness is central in all of the world's major religions, it has only recently been recognized by psychologists as a means of coping with distress when another person has wronged someone (or a third party) or has behaved in an unjust way (Pargament & Rye, 1998; Sanderson & Linehan, 1999). We include here not only personal injury, but also the negative feelings that are aroused when one reads about the mistreatment of others through the immoral use of power, which occurred during the Holocaust of World War II and continues to occur in the atrocities perpetrated upon innocent and helpless people at all too many places in the world. Theologies differ in terms of who may forgive—the victims or uninvolved others—but emotionally there is little doubt that people may be aroused by injustice anywhere. The result is often that such people harbor enmity and hatred of the perpetrators. Simon Wiesenthal's significant book *The Sunflower* (1976) poignantly discusses the issues raised by crimes against humanity, and presents a variety of religious perspectives related to the forgiveness of such transgressions.

Conditions for Forgiveness

Sanderson and Linehan (1999) claim that "all religious traditions offer similar practical instructions for forgiveness" (p. 210). The perpetrator of the injustice or wrong must do the following:

1. Accept personal responsibility for the act.
2. Express honest regrets.
3. Where possible, make appropriate reparation.
4. Make assurances that the offending action will cease.
5. Request forgiveness.

Forgiveness, however, is a two-way process; it includes both an offender and a victim. Both parties may suffer shame, anger, and injury, and both may be greatly distressed. Often, however, only one party may look to faith for understanding and the alleviation of pain and suffering. In cases such as this, where either the offender or the victim does not participate fully in the process, the position of the other party is exceptionally difficult. Pargament and Rye (1998) conceive of forgiving as a transformation. In coping with the wrong, the person who was hurt must shift from desiring revenge to desiring peace. (The perpetrator may be in a similar position.) What has been done must now be seen in a new light in order to reduce guilt and other negative feelings. Within a religious framework, pastoral counseling and therapy may be necessary to resolve the difficulty.

The Effects of Forgiveness: Empirical Studies

Given the place of forgiveness in institutional faith, it is no surprise that an emphasis on forgiveness usually accompanies being religious (Gorsuch & Hao, 1993). Even though research fails to show any direct effect by forgiveness on health, the potential for indirect effects exists. For example, as noted in Chapter 3, forgiveness is antithetic to hostility; it decreases both subjective and objective indicators of stress; and it also lowers blood pressure (an outcome that may reflect the previous two findings). Coyle and Enright (1997) have similarly shown reductions in hostility along with depression and anxiety.

In an effort to explain these findings, Worthington, Berry, and Parrott (2001) speak of a trait of "unforgiveness," which is associated with emotional, cognitive, and behavioral responses known to correlate negatively with health. We see the situations that arouse unforgiveness as threatening an individual's sense of control. The reaction is one of anger and/or fear. A religious or spiritual framework, via forgiveness, reduces inappropriate emotions and enhances the sense of control.

THE STATE OF RESEARCH ON RELIGION AND COPING

Nothing is ever as simple as we wish it were. The idea of research carries with it the notion of definitive answers—which is a myth. So often, studies are weak in controls, design, and data analysis. Chance also enters the picture and is especially pertinent when statistics are employed. Too many findings fail to be replicated. Unfortunately, overviews and meta-analyses of the work done in a field are rarely undertaken, but when they are carried out, we may be shocked to see how tenuous our assumptions are. In the realm of religion and coping, Pargament and Brant (1998) have done yeoman work that brings the necessity of caution to the fore. Table 15.2 summarizes this work.

Our basic hypothesis is of a positive association between some religious expression and the outcome of negative events. A positive relationship says that the situation worked out well; a negative finding indicates that the results were undesirable; and, of course, no relationship tells us that nothing could be inferred one way or the other. For example, in Table 15.2, 34% of the studies yielded positive results with religious orientations (e.g., individual religious expressions such as prayer, religious beliefs, church activity, intrinsic, extrinsic, and other faith forms). Only 4% were meaningfully negative, but 62% failed to provide any significant information. When we consider religious coping (e.g., seeking spiritual support, expressing spiritual discontent, participating in religious rituals), the studies revealed a higher percentage of positive than negative outcomes, but again nonsignificant relationships predominated.

These findings may shake one's confidence in the research, and we must rely on our own judgments of what the best work tells us. With regard to Table 15.2 and the role of religious orientations, our choice is between significant positive findings and nonsignificant ones. Overall, significant negative relationships seem to be too minor to be considered. The situation is not so clear regarding religious coping, and we are again left to our own resources. The tables in Pargament and Brant (1998) from which these summaries were derived do provide additional direction, as they further subdivide and detail studies under each of these

TABLE 15.2. A Summary of Studies on Different Aspects of Religion and Coping: Significant and Nonsignificant Findings

	Significant positive results	Significant negative results	Nonsignificant results
Religious orientations and negative event outcomes	34% (130)	4% (14)	62% (233)
Religious coping and negative event outcomes	32% (151)	21% (98)	47% (219)

Note. The numbers in parentheses are numbers of studies. Adapted from Pargament and Brant (1998). Copyright 1998 by Academic Press. Adapted by permission.

headings, and thus offer further guidance to scholars. Still, it is evident that the research waters are muddied, and that caution and questioning are the best guides.

CONTEXTUAL COPING CONCERNS

The concept of coping seems to have no limits. The content of this field varies from dealing with one's own outlook on life, to handling relations with others at home, work, school, and play, to dealing with the most tragic crisis situations that may be encountered. One person's petty annoyances can be another's sources of deep distress and depression. Therefore, it is necessary to consider contextual issues (both external and internal) that affect coping.

Faith and Coping with Daily Hassles

Coping begins with the needs of daily living, and is not restricted to handling crises. Some researchers have thus asked whether faith might play a role in adapting to the "hassles" of everyday life (Belavich, 1995). Noting that a number of adaptive coping strategies might be utilized, Belavich administered a carefully selected battery of tests to over 200 college students, and controlled for a variety of demographic variables. Sophisticated data analyses revealed that "religion plays a significant role in a person's experience with minor stressors on a day-to-day basis" (p. 24). Specifically, faith aids coping by diverting individuals from stress, and by enabling them to call upon the social support provided by other religious people and figures. Some aspects of religious coping were, however, related to poorer adjustment. The latter indicators—pleading and spiritual coping—implied a negative function. Conceptual efforts to explain these adverse findings call for further research.

The Effects of Contextual Consonance and Dissonance

The "hassles" of daily living may sometimes be implicit in one's life circumstances. We should therefore be sensitive to the social context of faith. Rosenberg (1962) studied consonance and dissonance between people's religious identification and the religious identifications of others in their surroundings. For example, a dissonant context would exist if a person was Jewish but his or her neighborhood was predominantly Christian. Consonance would, of course, mean that all neighborhood residents shared the same faith. Studying Catholics, Protestants, and Jews, Rosenberg observed that in a dissonant religious context, a person usually felt isolated from coreligionists and therefore lacked their support. Discrimination was also apt to occur. The long-range effects of contextual dissonance were likely to be low self-esteem, depressive feelings, and psychosomatic symptoms. A variation on this theme that merits study is dissonance in degree of religious commitment (i.e., the situation that exists when one's residence area is uniform in religious orientation, but the person is either more or less religiously involved than others).

Spirituality and Coping

Some valuable insights may be derived from the recent work of Socha (1999) on spirituality and coping. Emphasizing the "human existential situation," Socha goes beyond religion to a broader spiritual scheme. (See the discussions of "religion" versus "spirituality" in several previous chapters.) He offers a holistic, growth-oriented view, in which a person recognizes

the transitory nature of situations and acknowledges his or her own coping limits. Such awareness implies knowing when to define circumstances in terms of "sacredness"—a religious or secular notion of placing things in broader perspective. Belavich's (1995) work indicates what is done on a day-to-day basis; Socha's outlook suggests why, and introduces a different theoretical frame—a phenomenological approach that emphasizes how the individual perceives and explains the situation. This takes us back to the question of the meanings that precede the actions people take (another direction for research on coping and religion).

In other work relating to spirituality, Kennedy, Rosati, Spann, Neelon, and Rosati (n.d.), like Socha (1999), broaden the notion of coping from a focused pattern of responses to a broader approach based on making lifestyle changes. Working within a medically based program, these workers felt that their therapeutic procedures would constructively affect well-being and spirituality. Though they did not distinguish between religion-based and non-religion-based spiritualities, half of the participants in their program evidenced an increase in spirituality, and close to 100% reported an increase in their subjective sense of well-being. Positive and significant correlations were obtained among spirituality, well-being, and meaning. Distinguishing between faith-oriented and non-faith-oriented spiritualities should provide a substantive direction for further research, and may enable participants to utilize such avenues more effectively to make the desired lifestyle changes.

Religion and Positive–Negative Life Orientation

Another factor that contributes to effective coping behavior is whether a person takes a generally positive or generally negative perspective on life and its problems. This dimension is often treated as a general characteristic that includes attitudes toward both oneself and the world (Myers, 1992). Primarily viewed as trait-dependent, it is largely conceptualized in terms of optimism–pessimism. Its significance is well illustrated by a longitudinal study in which a pessimistic explanatory style manifested in early life predicted poor health in middle and old age (Peterson, Seligman, & Vaillant, 1988). Faith has been shown to be a significant component of optimism.

The association of religion with personal happiness is apparently a major function of faith in general (Ellison, 1991b). Extensive surveys of thousands of people in 14 countries have also shown a positive association between religiousness and feelings of well-being (Myers, 1992). Utilizing a variety of religious measures in national samples in the United States, Pollner (1989) concluded that "relations with a divine other are a significant correlate of well-being" (p. 100). In his system, religion's effectiveness results from the following: (1) It brings a sense of order and coherence to stressful situations; (2) it has been found to counter feelings of shame or anger that are aroused by stress; (3) it also creates positive feelings about oneself, simply as a result of having a perceived relationship with the deity; lastly (4) religion fosters a general tendency to see the self and the world in positive terms. In addition, there is strong evidence that religion, in offering a sense of meaning, control, and esteem, does support an optimistic outlook. This in turn helps people deal constructively with life, and seems to have long-range beneficial effects

Optimism–Pessimism and Fundamentalism

A common hypothesis is that a negative self-concept and low self-esteem should be associated with fundamentalist views, because of their emphasis on personal sin and guilt (Hood,

1992). To date, no consistent support has been found for this view. In fact, there is some indication that the opposite may be true.

Sethi and Seligman (1993) compared members of three different religious groups (liberal, moderate, and fundamentalist) on a variety of measures from which they derived indices of optimism and pessimism. Optimism was greatest among the members of the fundamentalist group, followed by those from the moderate group. The members of the liberal group evidenced the least optimism. Religious leaders were interviewed with regard to distinguishing the prayers and hymns typically used by the different faiths. A content analysis of these materials showed that theory paralleled the level of group optimism. In other words, the fundamentalist group was exposed to the most optimistic religious content, and the liberal group to the least. In related work, it was concluded that fundamentalism stresses the most hopefulness, the least hopelessness, and the least self-blame for negative happenings (Sethi & Seligman, 1994). There is a need to repeat this work with different procedures, however, since Kroll (1994) has raised questions about the validity of the optimism–pessimism measures used.

Religion, Self-Esteem, and Life's Meanings

We shift now to the related work on self-esteem and similar concepts. A recent large-scale study of almost 1,000 people in Australia found that belief in God, attending church, and praying correlated positively with self-esteem and well-being (Francis & Kaldor, 2002).

In a rather sophisticated effort, a deep personal identification with religion was found to be affiliated solidly with high scores on a measure of global self-esteem. This finding also held for scores on the measure of Intrinsic religious orientation, but not for either Extrinsic or Quest scores (Ryan, Rigby, & King, 1993). More recent work focusing exclusively on the Intrinsic measure confirms the foregoing finding (Laurencelle, Abell, & Schwartz, 2002).

Other fairly large-sample research (Delbridge, Headey, & Wearing, 1994) examined whether religious practice is directly associated with a favorable outlook on life, or whether there is an intervening factor. Specifically, does one's faith endow a person with a sense of purpose or meaning for life? This study points out that many different social and cultural referents offer meaning to people. For those who are religious, one's faith performs this role directly, and it may also do this indirectly in various ways. For instance, in addition to religious/spiritual resources, churchgoing provides social support—which, through its community integrative function, contributes to the feeling that life has a purpose.

Images of God and a Positive or Negative Sense of Self

Benson and Spilka (1973) showed that a positive outlook toward oneself corresponds to a similar perception of God. It is, however, well established that God concepts are multidimensional (Gorsuch, 1968; Spilka, Armatas, & Nussbaum, 1964). One long-standing dichotomy that is basic to Western religion is the one between notions of a loving God and a controlling God (Benson & Spilka, 1973; Spilka, Addison, & Rosensohn, 1975). Examining this dichotomy, Culbertson (1996) expected these images to relate to one's sense of personal shame. A controlling God concept was found to be positively affiliated with shame, but a loving God concept was independent of shame. Pargament et al. (1990) have observed that viewing God in a positive and benevolent light can buttress meaning, self-esteem, and one's sense of control in life.

Foster and Keating (1990) conducted a rather ingenious investigation into the relationships between male and female God images for men and women. They observed greater self-esteem when women interacted with a female God, while males viewed themselves more favorably when their God was masculine.

Religious Coping, Self-Esteem and Well-Being: Are They State- or Trait-Related?

Competence and success are the normal precursors to well-being, satisfaction with life, happiness, optimism, and self-esteem. This notion raises the question of whether competence and success in coping are functions of situations or more basic aspects of personality. In other words, are they state- or situation-dependent, or are they trait-dependent (Spielberger, 1966)? We may further ask whether the same is true of well-being and optimism. It appears that religion can be a part of this picture. In other words, using religion to cope successfully with life should relate positively to one's subjective sense of well-being, and, as implied above, the research literature overwhelmingly supports this hypothesis. According to Maynard et al. (2001), both state and trait considerations are pertinent when religious coping occurs.

Jones (1993) further notes that "extensive studies have found the presence of religious beliefs and attitudes to be the best predictors of life satisfaction and a sense of well-being" (p. 2). This is also the essence of the message that Pargament (1997) provides in his definitive volume on religion and coping.

RELIGION AND COPING WITH MAJOR STRESS

We have pictured living as a process of continuous coping. Clearly, religion can play a constructive role in handling the problems of daily life, but the real test of faith comes when common hassles are supplemented by the major trials of human existence—aging, illness, or disability; family, social, and economic difficulties; the loss of loved ones; and, of course, confronting our own death. In Chapter 8, we have looked at the last two issues.

The stress-buffering role of faith seems to have very broad application. Maton (1989) has shown that it relates positively to college adjustment among first-year students who have experienced high stress during the preceding 6 months. Newman and Pargament (1990) observed that religion also provides emotional support for college students and helps them redefine their problems. The need for new and positive meanings may be met this way. This redefining or "reframing" is a coping strategy that can be quite constructive. For example, caregivers of patients with dementia—who are placed in an extremely trying role—utilize their faith to redefine their situation and thus to make it more acceptable and manageable (Wright, Pratt, & Schmall, 1985).

Park, Cohen, and Herb (1990) point out that members of various faiths may differentially focus on prayer, seek group support, resort to sacred writings, or utilize positive thinking to cope with stress. They conducted a comparison of Catholics and Protestants, and found differences suggesting that religion may both alleviate and exacerbate stress. Given the fact that over 200 Protestant bodies exist in the United States alone, plus the strong ethnic variations that often parallel denominational distinctions, there is a need for additional work in this area to examine more exactingly defined religious bodies and the relative success of their approaches.

Hypothesizing that entering a university constitutes a very stressful experience for young people, Hunsberger, Pancer, Pratt, and Alisat (1996) attempted to get a large group of in-

coming first-year students to take a broad range of psychological tests. These were administered in blocks: prior to coming to the university, early in the first term, and late in the first year. Though a variety of religious measures (including one on fundamentalism) failed to relate to indices of adjustment, indices of religious doubt were consistently and negatively linked to indices of adjustment, including poorer relationships with parents and increased stress. Hunsberger et al.'s work suggests that the usual measures of religious belief and behavior may not be enough in studying coping behavior; the issue of religious doubt per se may need to be considered. Rejection of religion and religious doubt may well be different phenomena, and research illustrating their differential significance would make a nice contribution to the literature.

Having examined some of the major parameters surrounding the issue of religion and coping with major stress, and considering that Pargament (1997) wrote over 500 pages on this topic, it behooves us to focus on a few specific areas. To this end, we look first at the role of religion in enabling elderly persons to cope with the various stressors they confront (as well as religion's possible effects on longevity). We then select from the vast literature dealing with religion and health. Finally, we consider what is probably the most catastrophic stressor parents can face—the death of a child—and the ways religion can help parents deal with this tragedy.

Religion, Stress, and Elderly People

The Stressors of Old Age

Old age, the final stage in life, involves a number of particularly significant stressors. In a society such as ours that values individuality and progress, those who have retired and/or developed the infirmities of old age often find it difficult to avoid negative self-views and loneliness. Elderly persons are likely to interact less and less with younger people and may withdraw from social interactions in general. Again we confront the issue of disengagement, which we have mentioned in Chapter 8. Personally, socially, and economically, life for older individuals becomes increasingly problematic.

Erik Erikson (1963), the first modern thinker to develop a lifespan developmental psychology, pictured these last years as a struggle between ego integrity and despair. The individual must confront multiple issues of loss—the loss of various skills; the loss of personal significance through work after retirement; the loss of friends through death; and finally the knowledge that his or her own life may shortly conclude. As a 90-year-old Papago woman said some 70 years ago to an anthropologist, "It is not good to be old. Not beautiful. When you come again, I will not be here" (Underhill, 1936, p. 64).

In addition to the psychological difficulties of old age, elderly persons are increasingly beset by physical infirmities. Former strengths and capabilities are supplanted by weaknesses and the loss of muscle. Youthful beauty is replaced by wrinkles and white hair. There is a growing susceptibility to a wide variety of illnesses, such as cancer, heart disease, and arthritis. New aches and pains keep appearing as the years pass. All create new sources of unavoidable stress.

Religious Coping with Age-Related Stressors

Research has consistently revealed that religious coping mechanisms, especially prayer, are most frequently employed when senior citizens are dealing with health-related stress

(Conway, 1985–1986; Manfredi & Pickett, 1987). Turning to a deity for support appears to be the most effective strategy available to elderly persons with health problems. This holds true for persons of different ethnic groups, socioeconomic statuses, and widely varying levels of education (Koenig, George, & Siegler, 1988; Krause & Van Tranh, 1989).

Furthermore, whether the religious variables examined are attendance at services, beliefs, prayer, or church social support, all correlate negatively with depression and loneliness among elderly persons (Johnson & Mullins, 1989; Koenig, Kvale, & Ferrel, 1988; Pressman, Lyons, Larson, & Strain, 1990). Faith not only fosters long-range hope, but also creates optimism for the short-term future (Myers, 1992). Among senior citizens, religious involvement is a solid correlate of happiness (Myers, 1992).

One study of religiosity and time perspective found that religious people are more willing to look into the distant future and confront their eventual death than their nonreligious peers are (Hooper & Spilka, 1970). One's own impending demise is obviously a threat, and thinking about personal death is positively correlated with participation in religious activities by elderly persons (Fry, 1990). In addition, the salience of an individual's religion to self-image increases with age (Moberg, 1965a).

To sum up, the data are clear: religion is a powerful buffer against stress among the elderly. As Myers (1992) puts it, "the happiest of senior citizens are those who are actively religious" (p. 75).

Religion and Longevity

One may argue that the final test of the relationship between religion and aging may be found in longevity. Do religious people live longer than their less religious counterparts? A surprisingly large number of studies have addressed this issue. Even though most of this work indicates that religious involvement is associated with low mortality, the problem has proven to be far more complex than it appears on the surface. Because many variables confound the religion–longevity relationship, much research that has dealt either directly or indirectly with this issue has not produced clear or consistent results. For example, the tie between gender and faith shows that correlations between mortality and religion are stronger for women than for men. We cannot take this finding at face value, however, because women tend to outlive men. In addition, they use health facilities more often than men, insuring faster treatment for problems (Taylor, 1991). Clearly, researchers need to correct for gender.

The subtle influence of socioeconomic status may also complicate the religion–longevity issue. Higher status is associated with joining more organizations, and churches may be included in this picture (Chalfant, Beckley, & Palmer, 1981). Higher socioeconomic status also means more knowledge about health, greater use of medical services, and better quality healthcare. These factors will have an obvious impact on longevity. Similarly, indices of public religious involvement such as church attendance have been found to relate positively to longevity, but this might be due to the likelihood that nonattenders have poorer health that prevents them from going to church. These are only a few of many possible confounds; thus it is understandable that the more such variables are controlled for, the weaker the association between faith and longevity becomes.

Research on a sample of institutionalized chronically ill elderly persons claimed that those who died within the year were less religious (Reynolds & Nelson, 1981). This picture is muddied by the fact that they also had poorer prognoses and were more cognitively impaired. Another group of researchers reported that religion was positively correlated with

longevity, but only among elderly persons who were in poor health (Zuckerman, Kasl, & Ostfeld, 1984).

Richardson (1973) studied over 1,300 octogenarians and found religion to be unrelated to 1-year survival rates. More recent work by Koenig (1995) confirmed this finding. Idler and Kasl (1992), by contrast, found that public religiousness was related to lower disability and that private religiousness was linked to lower mortality. Moreover, for both Christians and Jews, there were significantly fewer deaths in the 30 days prior to a major religious holiday than for the same period afterwards (see Research Box 15.4).

Recognizing the need for a meta-analysis of data on this issue, McCullough, Hoyt, Larson, Koenig, and Thoreson (2000) conducted such an analysis on studies with samples totaling almost 126,000 people. (Remember that meta-analysis is a methodological/statistical procedure in which one gathers a great many data on a topic and analyzes them in order to resolve discrepancies and conflicting findings.) After considering some 15 possible confounding factors, these scholars found that religious involvement and longevity were positively related, but that the association was rather weak. For example, if we had two groups of 100 people each—one group being high in religiosity, the other less religious—we could expect to find at a later follow-up that 53 people in the less religious group had died, while only 47 in the more religious group had died. This outcome apparently held for public religious activity (e.g., church attendance), but not for private devotions. The association between religion and mortality was also stronger for women than men. McCullough (2001) offers a number of possibilities to account for these observations, opening the door to further research.

Research Box 15.4. Religion, Disability, Depression, and the Timing of Death (Idler & Kasl, 1992)

In this interesting study, the authors examined the effects of public and private religiosity on health, the ways in which these varied for Christians and Jews, and mortality rates around religious holidays. Starting with a sample of 2,812 people over 65 in 1982, Idler and Kasl reinterviewed the members of this group in 1983, 1984, and 1985.

By means of sophisticated data analyses, public religious participation in 1982 was found to be related to low functional disability in the following 3 years. Things were more complex with private religiousness: This was associated with greater disability in 1984, but an examination of who died and those who lived revealed that those engaging in private religiosity seemed to be protected against mortality.

Studying who lived and who died in the 30 days preceding and following religious holidays showed very strong effects relative to Easter for the Christian groups; the death rate was significantly lower prior to this holiday than after it. As expected, this did not occur for Jews relative to the Christian holiday, but was found for the Jewish holidays of Passover, Rosh Hashanah (the New Year), and Yom Kippur (the Day of Atonement). The pattern of reduced deaths prior to the holidays held for Jewish males but not for females. This variation was seen as a function of the greater role and investment of Jewish males than females in these holidays. This work shows a considerable potential for religious influence on both the health and mortality of elderly people.

Religion and Health

Religion, Stress, and the Immune System

Even though many illustrations and studies in the preceding pages have dealt with health, we now focus on this issue per se. Health is intimately connected to the defenses mobilized by the body when illness and infection are encountered. These stressors activate the body's immune system. One response is the release of a steroid hormone, cortisol. Secreted by the adrenal glands, cortisol has been called the "stress hormone." Too much or too little cortisol can be harmful to a broad spectrum of physiological activities. The negative effects of most interest here are elevated blood pressure, increased heart rate, indirect release of glucose for energy into the bloodstream, and possible problems with emotional control (Purves, Orian, & Heller, 1995; Stoppler, n.d.; Weber, n.d.). Especially in relation to the psychological effects, high levels of cortisol are considered undesirable.

Koenig, McCullough, and Larson (2001) review an immense medical literature in their *Handbook of Religion and Health*. They report research indicating that persons engaging in Buddhist meditation showed significant reductions in cortisol levels. In other work, female patients who resorted to prayer and religion while awaiting breast biopsies for possible cancer revealed less cortisol production than those not employing these methods. A study of women with metastatic breast cancer who evidenced religious activity and who considered faith important also showed lowered evening cortisol levels, but not reduced overall levels. In a number of other researches, the contributors to the *Handbook* found religion to be beneficial to the immune system with regard to other physiological indicators, such as interleukin. Apparently, therefore, religious and spiritual coping can reduce bodily expressions of stress.

Religion, Health, and Illness in General

We proceed now from the work on immune system function to the broader realm of health and illness in general. Levin and Schiller (1987) reviewed over 200 studies that related faith and health–illness, and concluded that the two domains are positively associated. However, a more recent survey of a portion of this literature for the year 2000 claimed that only 17% of 266 articles dealing with religion and cardiovascular disease showed such a relationship (Sloan & Bagiella, 2002). Criticizing the methodology of much of this research, these workers believe that the claims of religion's beneficial effects are greatly exaggerated. Obviously more meta-analytic studies need to be undertaken in this area, and over a broader range of illness.

This is another area where relationships are not simple, for even though some research finds "direct" connections between physical well-being and religion, these may work indirectly by fostering good health habits. Among these, faith (particularly an intrinsic religious orientation) counters the use of tobacco, drugs, and alcohol, and supports the use of seat belts, among other possibilities. Beliefs about prevention may also relate to religious commitment. A comparison of highly religious mothers with their less committed counterparts revealed that the former were significantly more likely to engage in active illness prevention behaviors than the latter group (Ameika, Eck, Ivers, Clifford, & Malcarne, 1994). Still, the more religious mothers felt that they had less control over illness. Since a major prevention category was to "go to the doctor," there might be an inclination here for religion to promote

deference both to God and to medical authorities. This possibility merits further assessment, as it may also imply a more general obeisance to authority. Finally, churches often actively sponsor a wide variety of healthful practices (e.g., dietary restrictions, prohibitions against alcohol and smoking); these are often adopted by believers (King, 1990; Levin & Schiller, 1987; Sarafino, 1990).

Even though religious groups may differ in vulnerability to certain illnesses because of diet and cultural factors, faith is associated with a low incidence of a number of cardiovascular conditions, hypertension, stroke, and different forms of cancer (Levin & Schiller, 1987). Another possibility is that since religiosity correlates positively with optimism, life satisfaction, and purpose in life, more religious people may be less inclined to report symptoms of illness and therefore downplay their possible significance (Kass, Friedman, Leserman, Zuttermeister, & Benson, 1991). This, of course, would work to their detriment, and does not appear to be generally true.

Another possible reason for the positive tie between faith and overall health may come from the observation noted earlier that religion seems to enhance one's sense of control, and that this is associated with better health (Loewenthal & Cornwall, 1993; McIntosh et al., 1985). This has been shown earlier in Research Box 15.1, with reference to a study on control, religion, and health (McIntosh & Spilka, 1990). In a large-scale community investigation, these results were further supported, but it was noted that religion was of particular benefit when people were dealing with either chronic illness or the death of loved ones (Mattlin, Wethington, & Kessler, 1990). In another study, resorting to one's faith was found to be the most useful coping device when dealing with such issues (McRae & Costa, 1986), which are addressed in more detail below.

Despite much research in these areas, there remain many unanswered questions. The mechanisms through which faith may operate in overall health and illness have yet to be identified. There is also a definite need for studies that control for religious affiliation, cultural differences, and behaviors that promote or damage health (King, 1990; Levin & Schiller, 1987). In addition, issues of response biasing have yet to be addressed. This is a fertile topic for further study.

Religion and Serious Illnesses

Hayden (1991) researched the utility of religion in helping patients with arthritis cope with pain—an important feature of this illness. He noted tendencies for a conservative religiosity and a sense of meaning in life to counter pain perceptions. These worked best with individuals who were not very depressed to begin with, and who believed that their faith could address their pain effectively. That there is a significant psychological component in the perception of pain goes without saying. Physical and psychological pain often go together, and a strong faith combined with being religiously active seems to counter pain-related distress, depression, and anxiety (Ross, 1990).

When serious, potentially fatal illness strikes, one can expect religion to be invoked rapidly and with telling effect. This is especially true when the problem is cancer. There is apparently a pervasive tendency to avoid blaming God for the bad things that happen to people, and to credit God for positive possibilities and outcomes (Johnson & Spilka, 1991; Spilka & Schmidt, 1983b). To the degree that patients with cancer view God as being in control of things, their sense of threat to life lessens, and their self-esteem improves (Jenkins & Pargament, 1988). An intrinsic religious orientation also counteracts feelings of anger, hostility, and so-

cial isolation (Acklin, Brown, & Mauger, 1983). In addition, patients may receive much social support from their coreligionists. We discuss cancer in greater depth below.

When the issue is hypertension, a review of the literature avers that high religious involvement seems to counter high blood pressure (Levin & Vanderpool, 1989).

Religion and Cancer: A Closer Look

The literature on the role of faith in serious illness clearly covers a broad range of maladies. In order to gain some perspective, let us confine ourselves to the literature on religion and cancer, particularly since the public identifies cancer with death. Though this association is markedly overdrawn in today's world, it is usually the first idea that comes to mind. In addition, though much research deals with people without reference to their sociocultural framework, let us also situate patients with cancer within their families, as this more poignantly allows us to recognize the seriousness of cancer in its natural context (Spilka & Hartman, 2000). Keep in mind that terms such as "patients," "people," and so on are abstractions that lose sight of the real meaning of the ramifications of the disease. Can anyone doubt this when we translate people, individuals, and persons into children, mothers, fathers, and other family members?

If a child contracts cancer, for instance, how do the child, siblings, parents, and other family members react? The child victim is likely to experience hospitalizations involving separations from others, as well as to experience much pain (both from the illness and from efforts to counter it). The effects of possible surgical procedures and chemotherapy can be particularly devastating. The predominant child responses are depression and anxiety (Spilka, Zwartjes, & Zwartjes, 1991). Though the age of the child is a factor, fear of death and a wide variety of other anxieties indicate extreme stress. The basic problems have been pictured as those of meaning and mastery (Hart & Schneider, 1997; Spinetta, 1977), and religion appears to meet these needs rather well (Spilka et al., 1991). Psychiatrist Robert Coles (1990) has written of the efficacy of prayer, religious ritual, and Biblical readings in helping children with cancer cope with their trials. Pargament (1997) points out how religion may also constructively deal with the mechanism of denial—a common factor in these circumstances.

Religion plays a role in helping parents and siblings cope as well. With regard to parents, the list of reactions to children's cancer is extensive, ranging from anxiety and fear to extreme marital distress and breakup (Enskar, Carlsson, Golsater, Hamrim, & Kreuger, 1997; Grootenhuis & Last, 1997; Leyn, 1976). Church social support and religion's potential for meaning and control can provide strong backing to parents in dealing with their children's illness and their own reactions (Zwartjes, Spilka, Zwartjes, Heideman, & Cilli, 1979).

Siblings may be plagued with anxiety about death, as well as guilt over their conflicted feelings toward their afflicted brother or sister. Anger toward parents may be also present as the parents shift their attention and concern to their ill child (Zwartjes et al., 1979). Faith, possibly with the aid of pastoral counseling, can work to resolve these sibling concerns and strengthen family ties in general.

When a parent is diagnosed with cancer, some different concerns are confronted. There is always fear of death; however, when a mother contracts cancer, the most common condition is breast cancer. In such a case, a daughter often worries about carrying the gene for the condition. The mother's response is often guilt, while both mother and daughter become anxious about the mutilation of mastectomy. Frequently religion is employed to cushion the blow (Johnson & Spilka, 1991).

Though more research needs to be done on religion and the effects on a family when a mother develops cancer, none seems to have been reported about what happens when a father receives a cancer diagnosis. Since he is usually the primary breadwinner, apprehension about economic matters may well be added to uneasiness about other disease-related issues. Extreme distress among the children is commonly observed under these circumstances (Hart & Schneider, 1997).

Whether the issue is serious illness in general or cancer in particular, when people feel that they can be active (e.g., do something constructive) in coping with their disease, they appear to benefit. Prayer, as has already been noted, is an active, cognitive coping strategy (Holahan & Moos, 1987), and patients with cancer who pray feel it is helpful both in reducing their pain and in aiding them to deal with their disease (Meyer, Altmeier, & Burns, 1992; Yates, Chalmer, St. James, Follansbee, & McKegney, 1981). The objective evidence supports such a position.

Religion and Coping with Disability

One of the earliest studies in the literature on religion and coping examined young people who were coping with paraplegia or quadriplegia, primarily as the result of accidents (Bulman & Wortman, 1977). This classic study is detailed in Research Box 15.5.

Religion and Coping with the Death of a Child

Our primary discussion of religion in connection with various aspects of death, including grief and bereavement, has occurred in Chapter 8. However, we feel that our discussion here of religion in relation to coping and adjustment would be incomplete without at least some

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Research Box 15.5. Attributions of Blame and Coping in the Real World: Severe Accident Victims React to Their Lot (Bulman & Wortman, 1977)

In a noteworthy research study, Bulman and Wortman interviewed 29 young people with paraplegia or quadriplegia, whose spinal injuries had occurred 12 months or less prior to their interviews. Objective measures of religiosity, internal–external control, and the concept of a "just world" ("people get what they deserve") were also administered to the sample. The interviews focused on who or what was to blame for the accidents that resulted in the spinal injuries, whether the accidents were avoidable, and how seriously the victims perceived what happened to them.

Those most likely to blame themselves tended to be highly religious and also felt that the accident could have been avoided. These individuals coped best with their condition. The most frequent explanation for an accident was that "God had a reason" for what occurred. Those who handled their problem best seemed to hold a "just world" view—a finding that is generally true of religious people. The authors emphasize the need for people to search for explanations that reflect an "orderly and meaningful world [more] than a need for a controllable one" (p. 362).

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consideration of the greatest disaster that can befall any parent—the death of a child. Indeed, religion may be of the utmost importance in coping with this most major of stressors.

Religion and Sudden Infant Death

We expect the old to die; we painfully acknowledge that younger people do die, mostly by accident; but the death of youngsters is something we want to deny. Still, it occurs, and the death of infants who have not yet had a chance to enjoy life is particularly upsetting. With all the publicity that sudden infant death syndrome (SIDS) has gotten in recent years, new parents often worry about such a possibility. (Fortunately, however, the death rate from SIDS has slowly declined from 1.5 per 1,000 in 1980 to 0.7 per 1,000 infants in 1998; U.S. Bureau of the Census, 2001.)

McIntosh, Silver, and Wortman (1993) have examined the role of faith following the death of an infant from SIDS (see Research Box 15.6). They found that religious participation elicited social support, and that religion helped bereaved parents for whom it was important to derive meaning from this calamity. In other words, parental faith supported the parents' efforts at cognitively processing the death of their child.

Other Studies of Religion and the Death of Children

The McIntosh et al. (1993) study suggests that religion as a coping device may be especially important when a devastating, uncontrollable event such as the death of a child occurs. Naturalistic explanations of a child's death are unsatisfactory for most people, because they imply no future, no hope—simply complete and total termination. In contrast, religious interpre-

Research Box 15.6. Religion's Role in Adjustment to a Negative Life Event: Coping with the Death of a Child (McIntosh, Silver, & Wortman, 1993)

This significant study examined how religion helped parents who lost an infant to SIDS adjust to this tragedy. A sample of 124 parents was studied; each set of parents was interviewed within 15 to 30 days after their child's death, and reinterviewed 18 months later. Adjustment and coping were related to four factors: religion, social support, cognitive processing, and meaning. The researchers hypothesized that religious participation would promote perceptions of social support and adjustment. They also expected that when religion per se was important to the parents, it would help them find meaning in the loss and aid cognitive processing of the event, and would enhance adjustment through these avenues. These hypotheses were supported. In addition, religious participation helped the parents derive meaning from their loss.

This study revealed that religion may not affect adjustment and distress directly; rather, it may work indirectly by bolstering perceptions of social support, aiding cognitive processing, and increasing the meaningfulness of an infant's death, probably by putting it in the context of a positive religious framework. Research such as this indicates the complexity of the role of religion in the coping process, and clarifies some of the mechanisms that are operative when a person's faith is tested by crisis and tragedy.

tations offer the potential of future life and other-worldly gratification for the deceased, and this-worldly answers that offer a measure of contentment for survivors. Mcintosh et al.'s (1993) study indicates this for parents who suddenly lose an infant to SIDS, and it has also been demonstrated for those who anticipate the death of a child from illness (Friedman, Chodoff, Mason, & Hamburg, 1963). Similar findings hold when parents have to deal with the deaths of premature and newborn infants (Palmer & Noble, 1986).

Maton (1989) offered evidence that spiritual support was particularly effective in countering depression and bolstering the self-esteem of parents who had recently lost a child as opposed to those whose offspring had died more than 2 years previously. Rollins-Bohannon (1991) found that church attendance was associated with a reduction in death anxiety for both parents and particularly for mothers, for whom it seems to lessen grief "related to feelings of anger, guilt, loss of control, rumination, depersonalization, and optimism/despair" (Cook & Wimberly, 1983, p. 237). In addition, there are indications that religious beliefs are strengthened by such tragedy when one already has a religious commitment.

Three different theodicies have been observed among bereaved parents: "1) reunion with the deceased in an afterlife; 2) death as a purposive event; and 3) death as punishment for wrong-doing on the part of survivors" (Cook & Wimberly, 1983, p. 237). These are regarded as attempts to make the death meaningful, and even to experience guilt feelings. Attributions to a purposeful God are also invoked when a friend dies, but people with an intrinsic religious orientation may undergo much cognitive restructuring in order to understand what has occurred, possibly because of their positive image of the deity. There is also the possibility that it is cognitively easier to deal with one's own death than that of another valued person (Park & Cohen, 1993; Schoenrade, Ludwig, Atkinson, & Shane, 1990).

OVERVIEW

A central theme in this chapter, if not this book, is that religion "works" because it offers people meaning and control, and brings them together with like-thinking others who provide social support. We have also suggested that these needs are satisfied through religious beliefs, experiences, and practices. These appear to constitute a system of meanings that can be applied to virtually every situation a person may encounter. Often premised upon scripture and/or a popular or civil religion, one finds God images that have the potential to explain both world and personal events (Spilka, Shaver, & Kirkpatrick, 1985). The deity is at one and the same time forgiving, loving, merciful, blessed, wrathful, involved in all human affairs, and simultaneously uninvolved since people have been "given free will" (Gorsuch, 1968). The many concepts of God that are held can be called upon as needed to explain occurrences that seem to defy naturalistic interpretations. People are loath to rely on chance. Fate and luck are poor referents for understanding, but the deity in all its possible manifestations can fill the void of meaninglessness admirably. There is always a place for one's God—simply watching, guiding, supporting, or actively solving a problem. In other words, when people need to gain a greater measure of control over life events, the deity is there to provide the help they require.

To hold a belief is to "know" something. As Herbert Benson (1975) has claimed, "the faith factor" is a powerful force in coping. It makes everything meaningful and strengthens our hand in dealing with the world. The internal mechanisms by which such beliefs work have not been determined, but no one can doubt that they can have profound effects.