Religious Orientation, Coping Strategies, and Mental Health

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Abstract

One hundred seventy-three Gustavus Adolphus College students (53 males, 120 females) aged 18 to 22 years participated in a study investigating the relationship between gender, religious orientation, coping preferences, and mental health (depression). Participants responded to Batson's Religious Orientation Scale (1993), COPE Inventory (Carver, Scheier & Weintraub, 1989), and CES-D Scale (Center for Epidemiologic Studies Depression), Radloff, 1977. It was hypothesized that an individual's religious orientation would correlate with his/her preferred coping mechanism, which would correlate with depressive symptoms. It was also predicted that gender would correlate with preferred coping strategies, religious orientation, and depression. Although religious orientation did not directly predict depression, it was shown to predict coping preferences, and coping preferences were shown to predict depression. Gender was also shown to predict external religiosity, preferred coping strategies, and depression. Further research investigating religious orientation and its role in positive or negative coping is warranted for use in counseling.

Religious Orientation and Coping Strategies

In a society increasingly concerned with religion, many psychological studies have investigated different aspects of the psychology of religion, such as the relationship between religiosity and prejudice (Allport & Ross, 1967; Batson, Flink, Schoenrade, Fultz, & Pych, 1986), religiosity and coping mechanisms (Holt, Clark, & Klem, 2007), and more recently, religiosity and depression (Bergin, Masters, & Richards, 1987; Holt, Clark, & Klem, 2007). William James began to increase psychologists' interest in religion by writing his book, "The Varieties of Religious Experience: A Study in Human Nature" in 1902. This interest was heightened after the atrocities of the Holocaust committed by religious individuals. Psychologists from all different fields of psychology tried to answer the question if religion is beneficial or harmful to the individual and society.

Gordon Allport was one of the first researchers to intensely focus on the relationship between religiosity and prejudice. He began to investigate the seemingly contradictory finding that highly religious people tended to be the most and least prejudice towards racial minorities. While studying this curvilinear relationship, he discovered that there was a relationship between people's religious orientation and prejudice behavior (Allport & Ross, 1967). Allport (1967) came to the conclusion that an individual can be intrinsically or extrinsically motivated to participate in religion. Individuals with an extrinsic religious orientation "use religion for their own needs" (Allport & Ross, 1967). Extrinsically religious people tend to use religion to increase their social status, security, and self-esteem. On the other hand, intrinsically religious people "find their master motive in religion" (Allport & Ross, 1967). For these

individuals, "religion is an end in itself" (Batson et al., 1986). All other needs are less important, and religion is the driving force in intrinsically individuals' lives.

Allport's studies found that even when controlling for educational differences, extrinsically motivated people are significantly more prejudiced than intrinsically motivated people (Allport & Ross, 1967). Allport believed that this was because "the inner experience of religion (what it means to the individual) is an important causal factor in developing a tolerant or prejudiced outlook on life" (Allport & Ross, 1967). This study also found that people who were indiscriminately pro-religious, meaning that they found all religious aspects to be positive, tended to be more prejudice than extrinsic and intrinsic individuals. Allport inferred that these finds were due to the fact that indiscriminately pro-religious individuals had lower education and overgeneralized all of religion's benefits. In turn, these same individuals would also overgeneralize minority groups and would not see individuals as distinct (Allport & Ross, 1967).

Daniel Batson expanded Allport's Extrinsic-Intrinsic Scale and added a new dimension, the Quest Scale (Batson et al., 1986). Individuals who view religion as a quest try to deeply understand religious issues and avoid clear-cut answers (Batson et al., 1986). These individuals understand that they will never find the absolute truth, but the process is deemed more important than the answers (Batson et al., 1993). Batson designed this new religious orientation because his previous study (Batson, Naifeh, & Pate, 1978) illustrated that intrinsically religious people might just try to appear non-prejudiced and give answers that make themselves look more open-minded.

More recently, the psychology of religion has been applied to the research area of clinical psychology and counseling. Religion is extremely important to American

society, and psychologists have begun to incorporate aspects of it into counseling. According to a 1999 poll of United States residents, 97% of Americans believe in some type of god and 90% pray (Gallup & Lindsay, 1999). According to the 2008 Pew Forum on Religion & Public Life (http://pewforum.org/about), 76.2% of the United States' population is officially affiliated with a specific Christian denomination, and 6.6% of the population is officially affiliated with a specific non-Christian denomination (Islam, Judaism, etc.). Only 16.1% of the 35,556 participants surveyed identified as non-affiliated (Pew Forum, 2008). Since religion is so important in America, clinical psychologists and counselors have tried to decide if religion is harmful or beneficial for individuals. Overall, most studies have found that religion tends to have a positive influence in individuals' lives (Bergin, Masters, & Richards, 1987). Religion has especially been shown to be an effective way of coping with stress (Hot, Clark, & Klem, 2007).

The fields of counseling psychologists and clinical psychologists have become increasingly interested in ways that people cope with stressors (Carver, Scheier & Weintraub, 1989). According to Carver, Scheier, and Weintraub (1989), coping is defined as the process of executing a potential response to a threat. Psychologists commonly agree that there are both positive and negative ways to cope, but psychologists still debate which strategies are considered positive and which are considered negative. Some studies have provided evidence that religious individuals tend to use more effective coping mechanism (Holt, Clark, & Klem, 2007). Other studies have more specifically examined the relationship between specific ways of coping and their effectiveness in alleviating mental health symptoms (Bergin, Masters, & Richards, 1987).

Carver, Scheier, and Weintraub (1989) composed a multidimensional coping inventory to try to classify people's different preferences for coping strategies. According to this particular measure, individuals can prefer problem-focused coping, emotion-focused coping, and/or poor coping mechanisms. This measure tests preferences for specific strategies and then groups these preferences into the three broader categories. Problem focused coping includes active coping, planning, suppression of competing activities, restraint coping, and seeking of instrumental social support. Individuals tend to prefer problem focused strategies when people are looking for a constructive solution. Emotion focused coping includes seeking of emotional social support, positive reinterpretation, acceptance, denial, and turning to religion. Emotion focused coping tends to be used when people feel that there is little that can be done to change the situation and they need to just deal with it. Poor coping mechanisms can include both problem and emotion focused strategies which include the venting of emotions, behavioral disengagement, mental disengagement (Carver, Scheier, & Weintraub, 1989).

Carver, Scheier, and Weintraub (1989) examined the relationship between coping preferences and different personality traits. They found that highly optimistic individuals tended to prefer problem-focused strategies. Conversely, individuals who tended to prefer denial and disengagement were less likely to have internal control, optimism, or high self-esteem. Denial and disengagement was also positively correlated with anxiety. These findings have led researchers to believe that problem focused strategies are used more by well adjusted individuals. This style of coping may provide a buffer from life's constant stressors.

The findings from the previous study and other studies helped increase researchers' interest in the relationship between religion, coping mechanisms, personality traits, and mental health symptoms. The Religious Orientation Scale (Batson, 1993), which was initially used as a tool to examine the relationship between religiosity and racial prejudice, started to be used to investigate the relationship between religiosity and mental health. Bergin, Masters, and Richards (1987) hypothesized that religiosity might be related to more than just prejudice behavior.

Bergin, Masters, and Richards (1987) found support that highly intrinsic individuals were more likely to exhibit better personality functioning than highly extrinsic individuals. Specifically, the researchers found that intrinsic individuals have less anxiety and more self-control. No correlations were found between religious orientation and irrational beliefs or depression. This may have been because the measure of depression used was for clinical populations, and the study was given to a non-clinical population at a university.

For the current study, it was hypothesized that religious orientation and gender would predict mental health (at least in terms of depression). It was also predicted that there are gender differences in religious orientation, preferences for coping strategies, and depressive symptoms. Finally, it was predicted that preferences for coping strategies will predict religious orientation and mental health (depression).

Method

Participants

One hundred seventy-three (53 males, 120 females) participated in this study at Gustavus Adolphus College, a private Lutheran liberal arts school. One hundred fifty-one participants were general psychology students offered three extra credit points for their participation. The other twenty-two participants were members of Gustavus Youth Outreach (GYO), a student-led religious organization that leads church retreats for youth. The mean age of the participants was 19.00 years, with a range from 18.0 to 22.0 years. The students came from diverse religious traditions. 49.1% identified as Lutheran ELCA, Lutheran Missouri Synod, or Lutheran unspecified, 16.8% identified as Catholic, 6.9% identified as non religious or agnostic, 3.4% identified as non-Christian, and 23.7% identified as other Protestant denominations. The students were informed of the true purpose of the study and answered four brief questionnaires.

Materials

Basic Questionnaire. This questionnaire measured basic demographic information such as age, major, ethnicity, and personal and parental religious affiliation. The questionnaire also asked about the weekly frequency of religious social activity, worship, and prayer/meditation.

COPE Inventory. (Carver, Scheier & Weintraub, 1989). This scale measures individual's tendencies to prefer problem focused, emotion focused, or poor coping mechanisms.

Center for Epidemiologic Studies Depression (CES-D). (Radloff, 1977) This scale measures depressive symptoms in the past week in non-clinical populations.

Religious Orientation Scale. (Batson et al., 1993). This scale was originally developed by Gordon Allport (1967). Allport's (1967) original scale measured individuals' tendencies to be high or low in extrinsic and/or intrinsic religious orientation. Daniel Batson (1993) expanded the scale and added a third type of religious orientation, religion as a quest. The scale used in this study is a combination of the two and measures people's tendencies to be high or low in Internal (Intrinsic), External (Extrinsic), or Religion as Quest religious orientations.

Procedure

Students participated in this study in one of three ways. Ninety students completed the study during the fall semester. Participants were greeted, signed consent forms, and given directions. They were told that their responses were confidential and that they could leave at any time if they were uncomfortable. Upon completion of the four questionnaires, participants were thanked and given a feedback sheet explaining the purpose of the study.

The second group of participants were presented were given the same instructions and completed the same questionnaires in the same order on a web browser on the participants' computer screen.

The third group of participants were members of Gustavus Youth Outreach (GYO). They followed the same procedure as other participants. They were greeted, signed consent forms, completed the questionnaires, and received feedback sheets. These participants were not offered any reimbursement for their participation.

Results

An independent samples t-test was used to examine the relationship between gender and depression. Women were more likely to exhibit depressive symptoms than men ($t(125)=-1.98$, $p<.05$), as exhibited in Figure 1.

Insert Figure 1 about here.

A multivariate linear regression analysis was used to assess the relationship between depression and religious orientation (internal religiosity, external religiosity, and quest orientation). No significant relationships were found. The beta values for the predictors were -.211, .125, and .059, respectively.

An independent samples t-test was used to examine the relationship between gender and religious orientation. It revealed that men and women significantly differed in their external religiosity. Women are more likely to exhibit external religiosity than men ($t(104)=-1.98$, $p<.05$), as exhibited in Figure 2. No significant relationships were found for internal religiosity or quest orientation.

Insert Figure 2 about here.

An independent samples t-test was used to examine the relationship between gender and coping preferences. Women were more likely to use the emotion focused coping strategy than men, $t\ (95)=-3.94$, $p<.05$, as exhibited in Figure 3.

Insert Figure 3 about here.

Women were also more likely to use poor coping mechanisms than men, t (108)= -2.5, p<.05, as exhibited in Figure 4.

Insert Figure 4 about here.

No difference was found for preference of the problem focused coping strategy. A multivariate linear regression analysis was used to examine the relationship between coping preferences and depression. Individuals who use poor coping mechanisms were significantly more likely to exhibit depressive symptoms, t(170)= 7.37, p<.01, as exhibited in Figure 5.

Insert Figure 5 about here.

It was also shown that individuals who were high or low in problem focused or emotion focused coping strategies were more likely to exhibit depression than those who used moderate amounts of the two strategies, as exhibited in Figures 6 and 7.

Insert Figures 6 and 7 about here.

A multivariate linear regression analysis was used to assess the relationship between religious orientation and coping preferences. Individuals high in quest orientation were significantly more likely to prefer problem focused coping strategies, $t(170) = 3.01$, $p < .05$, as exhibited in Figure 8.

Insert Figure 8 about here.

It was also shown the highly externally religious individuals were more likely to prefer emotion focused coping strategies, $t(170) = 3.13$, $p < .05$, as exhibited in Figure 9.

Insert Figure 9 about here.

Discussion

The study examined the relationships between gender and mental health, religious orientation and mental health, gender and religious orientation, gender and coping preferences, coping preferences and religious orientation, and coping strategies and mental health. It was found that women exhibit more depressive symptoms than men, consistent with previous research (Nagoshi, Terrell, & Nagoshi, 2007). Religious orientation did not appear to directly predict depression. Males and females did not differ in their preferences for quest orientation or internal religiosity, but it appeared that women are more likely than men to be externally religious. It was also shown that women were more likely to use the coping strategy of emotion focused and poor coping mechanisms than men, but no difference was found for the coping preference of problem focused. Individuals high in specific religious orientations were also shown to have preferences for certain coping mechanisms. Individuals high in quest orientation were significantly likely to prefer problem focused mechanisms. Individuals high in external religiosity were also significantly likely to rely on the strategy of emotion focused coping. Finally, poor coping strategies were correlated with higher depression than those who used fewer poor coping strategies.

These findings were reasonably consistent with previous research. The pronounced gender differences in external religiosity, coping preferences and depression have all been shown in previous studies. These findings help provide validity to the other findings in this study. Like Bergin, Master, & Richards (1987), it was not found that religious orientation is directly correlated with depression. It may be that religious orientation is more related to personality traits than to an actual mental health measure.

One way that this study differed from previous studies is that it was not shown that problem focused coping strategies were more effective in alleviating depression than emotion focused coping strategies. It seemed that individuals who moderately relied on the two strategies had the fewest depression symptoms. This may encourage moderation in any type of coping preference. Further research is warranted to see if the amount of emphasis placed on a particular strategy affects the outcome. It may be that certain strategies are over emphasized and others are under emphasized.

This study may have had a few limitations. The researcher decided to simply classify people as high or low in the external, internal, or quest dimensions of religious orientation. Previous studies were more discriminate and only qualified as intrinsic if there were also low in extrinsic, and vice versa (Bergin, Masters, & Richards, 1987). Differences may have been more pronounced between groups if this discrimination was made.

This study opens up possibilities for further research. An interesting finding was that besides its relationship to problem focused coping, there were no significant findings for the quest orientation. It may there is something unique about quest orientation during the college years. Individuals identifying as quest may be questioning any type of formalized religion, which really is not a quest orientation, though they may have scored high on this measure. Typically, this measure has been used with religious middle age adults already confident in their faiths (Allport & Ross, 1967). It may be that researchers need to relook at the wording of the questions to factor in for this consideration. As the scale is now, there are no questions that test for individuals who are anti-religion or questioning their faiths. Future studies may employ a longitudinal study to investigate

the changes in an individual's religious orientation from a period of discovery (college) to a period of relative stability (middle age).

Future studies examining the relationship between religious orientation, depression, and coping mechanisms may want to specifically focus on using religion as a specific coping mechanism. Individually analyzing the components of problem focused, emotion focused, and poor coping mechanisms may provide a more detailed analysis of strategies that are working for individuals.

This study has implications for the field of clinical and counseling psychology. Understanding an individual's religious orientation may help therapists understand the patient's way of dealing with stress. It might be that even seemingly positive coping strategies will not work with every individual. Different strategies work for different people.

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Figure Captions

Figure 1. Gender and Depression.

Figure 2. Gender and External Religiosity.

Figure 3. Gender and Emotion-Focused Coping.

Figure 4. Gender and Poor Coping.

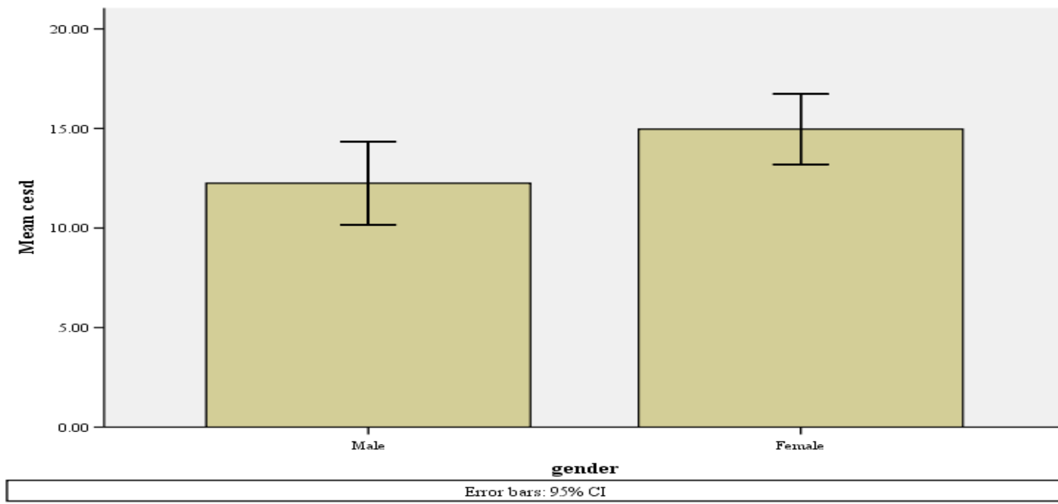
Figure 5. Poor Coping and Depression.

Figure 6. Problem Focused Coping and Depression.

Figure 7. Emotion Focused Coping and Depression.

Figure 8. Quest Based Orientation and Problem Focused Coping.

Figure 9. External Religious Orientation and Emotion Focused Coping.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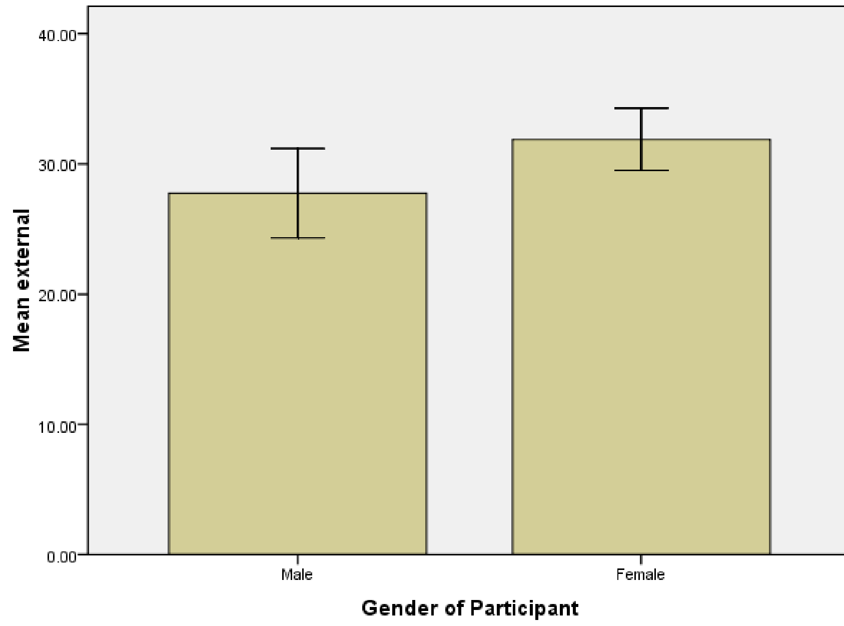
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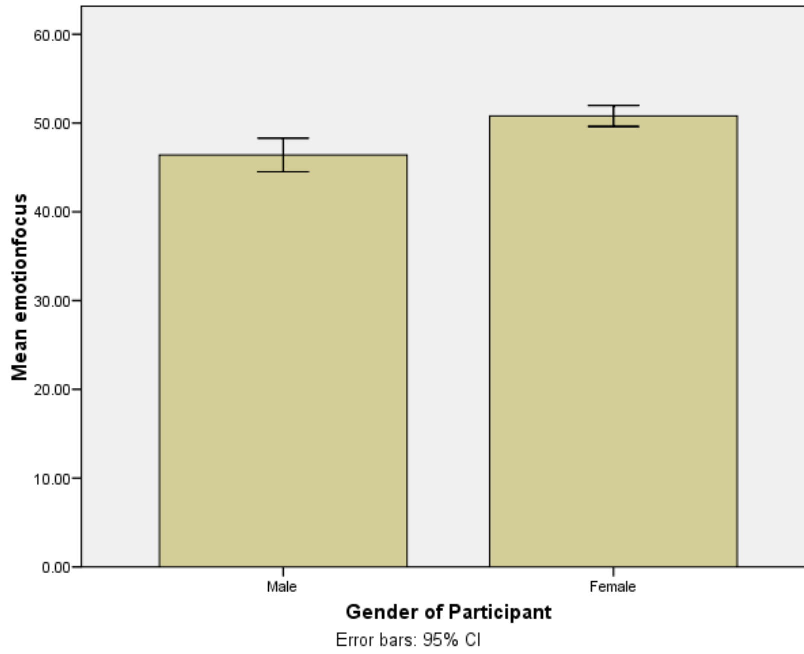
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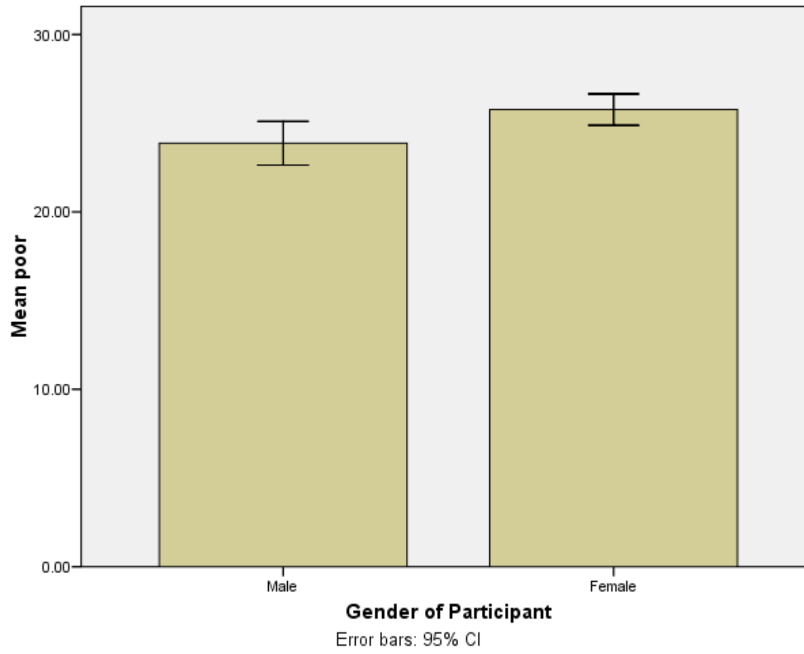
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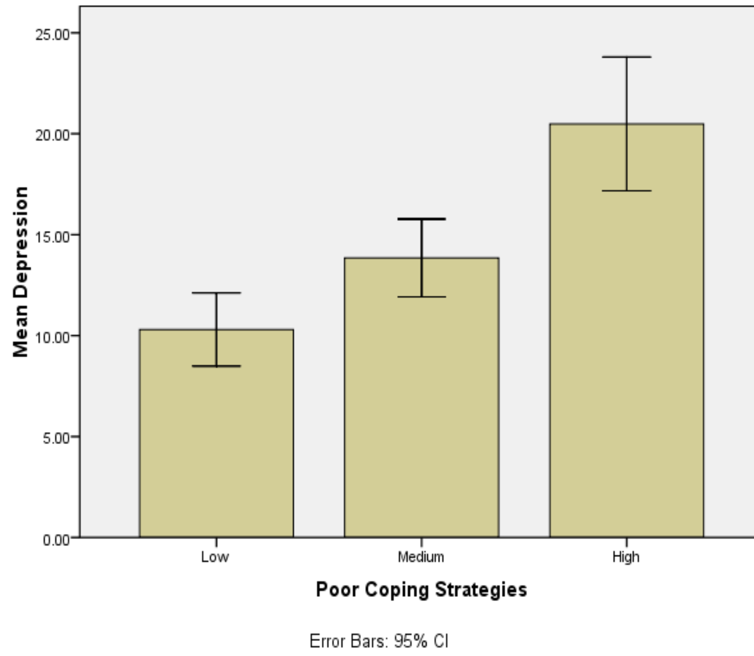
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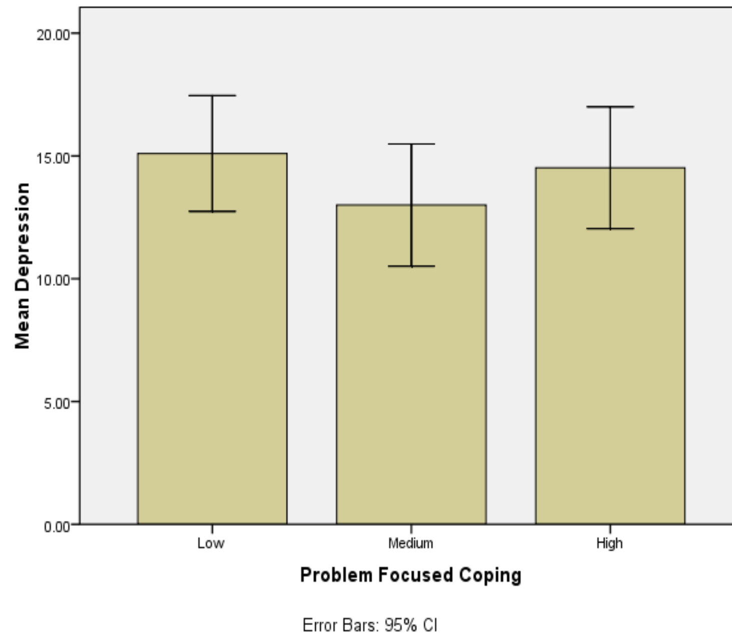
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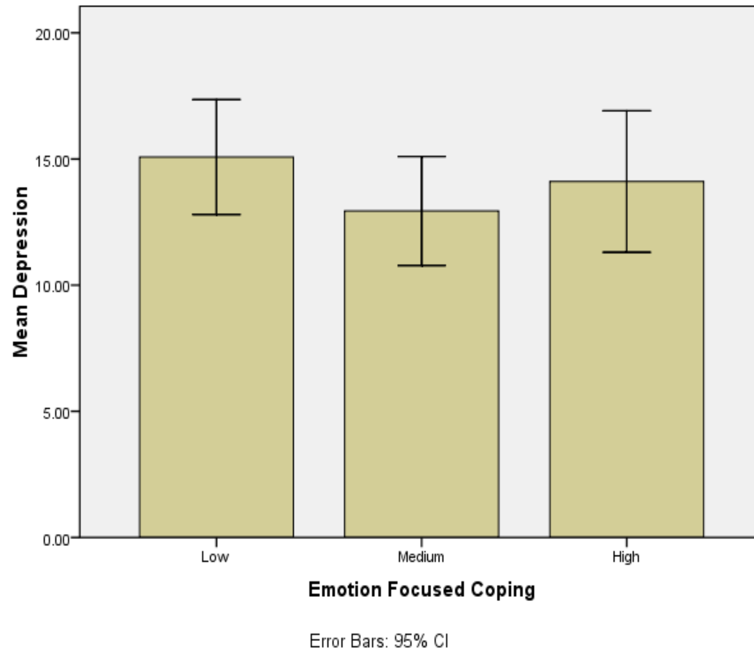
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Error Bars: 95% CI

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	46.216	2.252		20.524	.000
	internal	-.098	.066	-.178	-1.475	.142
	external	.113	.076	.179	1.485	.140
	quest	.123	.041	.228	3.014	.003

a. Dependent Variable: Problem Focused Coping

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	39.797	1.667		23.867	.000
	internal	.096	.049	.205	1.956	.052
	external	.175	.056	.330	3.136	.002
	quest	.058	.030	.126	1.906	.058

a. Dependent Variable: Emotion Focused Coping