College of Saint Benedict and Saint John's University

DigitalCommons@CSB/SJU

4-2015

Factors Influencing the Likelihood of Using Religion as a Coping Mechanism in Response to Life Event Stressors

Nicole R. Cornell
College of Saint Benedict/Saint John's University

Follow this and additional works at: https://digitalcommons.csbsju.edu/honors_theses

Part of the Religion Commons, and the Sociology Commons

Recommended Citation

Factors Influencing the Likelihood of Using Religion as a Coping Mechanism in Response

to Life Event Stressors

AN HONORS THESIS

College of Saint Benedict/Saint John's University

In Partial Fulfillment

of the Requirements for All College Honors

and Distinction

in the Department of Sociology

by

Nicole Cornell

October 2014

Advisor: Christopher P. Scheitle, Ph.D.

Factors Influencing the Likelihood of Using Religion as a Coping Mechanism in

Response to Life Event Stressors

Nicole Cornell, College of Saint Benedict/Saint John's University

Approved by:

_____

Dr. Christopher P. Scheitle
Adjunct Assistant Professor of Sociology

_____

Dr. Jeffrey J. Kamakahi
Associate Professor of Sociology

_____

Dr. Linda R. Tennison
Associate Professor of Psychology

_____

Dr. Sheila M. Nelson
Chair, Department of Sociology

_____

Dr. Emily Esch
Director, Honors Thesis Program

Stress is an aspect of daily life. Stressors can be mentally taxing to an individual and cause negative effects when it comes to health. To combat stress, most individuals implement one or more personal coping mechanisms. However, though individuals may encounter similar stressors in life, each person combats the accompanied stress in vastly different ways. In some cases, individuals turn to religion to make sense of their circumstances and buffer their stress (Nash 2006; Jacobson, et al. 2006). Most previous research has looked at whether religion functions as an effective coping mechanism while not necessarily addressing why certain people use religion and others do not. In this way, religion has primarily been treated as an independent variable by previous studies rather than a dependent one. This study examines religion as a dependent variable and uniquely focuses on the societal elements and differentiations that contribute to the likelihood an individual will utilize religious coping in relation to a life event stressor in the first place. Knowledge of this result can lead to better understanding of patients' needs by understanding the way social background affects a patient's perceived available resources for coping with stress. An increased awareness of differentiation in coping mechanisms in relation to patient care has the possibility to contribute to the offering of more comprehensive care resources.

Religion and Health

Numerous studies have looked at the religion and health connection even before its application to the stress process. Most notably in the history of religion and health connections is French sociologist, Emile Durkheim's, famous 1897 study of the difference in suicide rates among Protestants, Catholics, and Jews to which he attributed extrinsic and intrinsic causes (Levin 1994). Durkheim concluded in his study that the stronger social control and levels of societal integration found among Catholics led to lower suicide rates than that of Protestant

denominations in which group attachment and regulation of behaviors were not as closely tied to the faith tradition.

Moving forward through time, in the last several decades there has been increased interest in the relationship between health and religion. Marks (2005) concluded in his study on religion and bio-psycho-social health that there exists a positive relationship between dimensions of religion and factors of bio-psycho-social health. Additionally, Ellison and Levin (1998) found that simply believing or expecting religious practice to benefit health may be enough to account for positive health outcomes among religiously committed people. Religion has been attributed to improving mental health, setting precedence for physical health, functioning as a social support mechanism, and as an intrapersonal resource (Koenig, McCullough, Larson 2001; Krause 2011; Pargament, et al 1988). Across various studies by differing disciplines and individuals, "religiosity, however operationalized, seems to exert a salutary effect on health, regardless of the outcomes or diseases or types of rates which are examined" (Levin 1994: 1476). With such diversity in findings, religion and health can be assumed to have an association.

Health, however, can be a term used to encompass most degrees of a human's bodily, mental, and spiritual condition. This study specifically focuses on stress as it is a social phenomenon that affects all aspects of the human health spectrum. The association between religion and health has broad ramifications when applied to the stress process, coping mechanisms, and the sociological study of stress.

Sociology of Stress

Stress can be studied through the sociological lens as a way to uncover patterns and regularities shared by people with common characteristics, such as social or economic backgrounds. When referring to the stress process, stress can be defined as "environmental

demands [that] tax or exceed the adaptive capacity of an organism, resulting in psychological and biological changes that may place persons at risk for disease" (Krause 2011: 208). However, the mere occurrence or outcome of stress is not at the center of the sociological study of it.
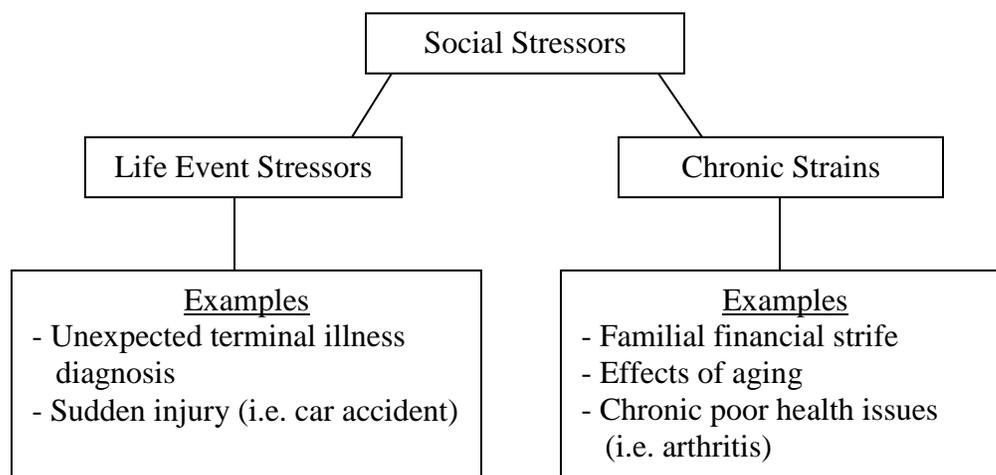
Sociology is particularly interested in stress as "it reveals patterned differences among groups and collectives differentiated by their social and economic circumstances" (Pearlin 1989: 244-245). Distinct and yet complementary to the health sciences, sociologists are interested in the organization of lives and structures of society that shed light on the stress process and the factors that influence the development of an individual's coping response to stressors. Whereas a psychologist might approach stress as the individual's internal reaction to a stimulus and a doctor as a physical or behavioral one, sociologists approach the study of stress by understanding the individual's background and environment and how these might influence their response to the stressor. Stress, similar to the feeling of embarrassment, is a product of our social environment and is a social phenomena caused by social entities around people, such as schoolwork, marriages, or the workplace. This distinct focus leads to the importance of studying stress from a sociological angle as it contributes a different perspective through which both stressors and the anticipated response of people to the stressors can be studied. The importance of studying the stress process through a sociological lens expands beyond just its discipline as "the study of religious coping patterns may be practically useful to religious, health, and mental health professionals in both assessment and intervention" (Pargament, et. al 1998: 722). These findings can be used to further understand the social factors behind utilization of specific coping mechanisms by individuals.

The sociological study of stress can be applied to various aspects relating to the stress process. This includes the presence of social stressors in the environment and the variation in utilization of coping mechanisms. Both the interpretation of social stressors and the

implementation of various coping mechanisms are related to the social values an individual has absorbed from their environment and come to understand. By utilizing a sociological lens, the way in which various social values influence reactions to stressors and subsequently lead to a form of coping can be more thoroughly understood.

Social Stressors

The stress process is composed of stressors, mediators, and outcomes. These components are found in different types of social stressors. Social stressors come in two broad categories – life events and chronic strains. Life event stressors are occurrences that lead to a drastic change in quality of life and are usually unwanted and uncontrolled. Chronic strain stressors are more enduring and recurrent life problems. The presence of chronic strain stressors already in an individual's life can further increase the likelihood an individual seeks out the utilization of a coping mechanism when a major life event stressor does occur. Both of these subsections of social stressors can be better understood by the figure below.

```
                         ┌─────────────────────┐
                         │  Social Stressors   │
                         └─────────────────────┘
                          /                    \
         ┌────────────────────┐       ┌────────────────────┐
         │ Life Event Stressors│       │  Chronic Strains   │
         └────────────────────┘       └────────────────────┘
                  │                             │
  ┌───────────────────────────────┐ ┌───────────────────────────────┐
  │           Examples            │ │           Examples            │
  │ - Unexpected terminal illness │ │ - Familial financial strife   │
  │   diagnosis                   │ │ - Effects of aging            │
  │ - Sudden injury (i.e. car     │ │ - Chronic poor health issues  │
  │   accident)                   │ │   (i.e. arthritis)            │
  └───────────────────────────────┘ └───────────────────────────────┘
```

When studying stress, it is integral to consider an individual's socialization environment in search of links that "join broader dimensions of social organization to personal stress" (Pearlin 1989: 243). Social values define what is to be considered good, desirable, and prized or if

something is to be deemed eschewed. The differentiation in social values helps explain why individuals, who are exposed to the same stressor, do not necessarily have the same reaction or outcome to it (Pearlin 1989). Learned stress mediation methods, usually employed with chronic strains, are often reflections of what an individual has been taught to use rather than being a product of their social values. Having said that, this study is particularly focused on life event stressors, as the coping methods associated with such stressors tend to be products of the individual's social values rather than taught methodology.

Coping Mechanisms

From a sociological perspective, coping is important because it is "learned from one's membership and reference groups in the same ways as other behaviors are learned or internalized" (Pearlin 1989: 250). This focus narrows down looking from the function of coping to the forms of coping and the social values and factors that affect its choice of utilization by various people. Particular interest is paid to the ways the organization of religion as a formation tool of an individual's social values affects a person's coping mechanisms in relation to stress. With this regard, the interest of this study is in the relationship between the social and personal circumstances of an individual and their use of religion as a coping mechanism to stress. Additionally, this study is interested in the utilization of religious coping by the individual incurring the life event stressor, not the coping mechanisms employed by those in relationship with that individual.

To better understand the variation in dealing with stress, sociology seeks to define the ways in which an individual's social values contribute to his or her reaction to the stressor through the study of outcomes and employment in the stress process. A variety of coping mechanisms are employed when dealing with life event stressors. However, these various

methods are not employed evenly by all individuals who encounter similar stressors. This is true in the case of religious coping.

Religious Coping and Stress

Individuals, based on differing social values, will utilize various coping methods to deal with the mental stress of a life event. Overall, coping is defined as, "efforts, both action-oriented and intrapsychic, to manage…environmental and internal demands…which tax or exceed a person's resources" (Ellison and Henderson 2011: 24). With 79 percent of Americans believing that God answers prayers for healing from incurable diseases and 64 percent thinking doctors should pray with a patient if the patient requests it, religious coping presents itself as an important avenue of research in coping with stress related to a life event stressor (Idler, et al 2003: 330). Religion, in the case of this study, simply refers to "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent" and the expression of such a belief in conduct and ritual (Koenig, McCullough, Larson 2001: 18).

The stress process itself involves the interaction and interplay between stressors, resources, and mental health outcomes. Therefore, there is a variety of different coping strategies that can be utilized independently as strategies for dealing with stress. Though this study focuses exclusively on religious coping, it does not suggest that the utilization of religious coping always precludes the independent use of other coping strategies in response to the same life event stressor. Individuals could employ a variety of coping mechanisms at once. However, some religious traditions' beliefs may preclude the use of other coping mechanisms. Focusing on exclusivity of these religious traditions' and the effect of their beliefs is not within the ramifications of this study as this study simply seeks to understand the broad range of social factors that influence the likelihood of utilizing religious coping in general.

Religious beliefs, a core component of religiousness, play a central role in the stress process as a buffering resource in preventing the effects of stress on mental health (Schieman and Bierman 2011). Previous studies on religious coping and stress have primarily focused on the outcomes of religious coping and different styles of it, while giving little attention to the social values that would lead an individual to utilize this form of coping in the first place. The linkage between religion, health, and its practical uses in the stress process has, however, led to various studies looking into the outcomes and ramifications of this relationship.

Religion as Mediator of Stress

Though not of particular focus in this study, it is important to consider the studied outcome effects of religion on the stress process. Understanding the way religion effectively or ineffectively influences an individual's ability to deal with stress gives perspective as to the outcome of religious coping before investigating the factors that influence the initial use of it.

Over time, various studies have affirmed both positive and negative outcomes of religious coping on mental health (Koenig, McCullough, Larson 2001). In one sense, religious coping offers resources that help with the facilitation of coping. Individuals who have higher levels of religiousness tend to have greater social support and satisfaction with support when it comes to dealing with stressors (Koenig, McCullough, Larson 2001). Additionally, internalized religion can reduce the mental stress associated with a major life event by encouraging active problem solving, advocate acceptance, turning the problem over to God, and focusing on others in worse conditions than oneself (Koenig, McCullough, Larson 2001).

Religious coping methods are able to mediate the relationship between an individual and the mental stress incurred from a stressor. Religious coping can be related to better mental health and better adaptation to stressors (Koenig, McCullough, Larson 2001; Pargament, et. al 1998). In

relation to physical health, religion does less mediating and more setting a precedent for healthier living by encouraging healthy lifestyle choices and behaviors as well as better psychological health as a deterrent for some physical diseases (Koenig, McCullough, Larson 200; Blasi 2011). The importance of religion as both a mediator and a precedence setter in relation to health begs for further investigation into the social values and societal aspects behind its usage.

Religion as Stressor

However, religious coping methods also have the potential to produce negative mental health outcomes. Some researchers and health professionals argue that religion has no effect or adverse effects on health, both physical and mental (Koenig, McCullough, Larson 2001). These negative outcomes could include excessive devotion leading to neglect and disruption in other parts of life, rigid thinking and compulsory actions, and excessive reliance on the supernatural thus delaying needed health care or counseling (Koenig, McCullough, Larson 2001). Additional negative religious coping outcomes can be spiritual discontent, punishing God, and reappraisal of God's powers (Pargament, et. al 1998). Overall, religious practice may lead to positive outcomes such as forgiveness, contentment, and love, but has potential to also arouse negative emotions like guilt or fear (Ellison and Levin 1998). With such mixed results as health outcomes, it is curious as to what prompts certain individuals to engage in the process of religious coping to begin with and what type of social factors can predict such usage.

As expressed in the literature above, though religion can lead to the development of negative coping, overall religion has a positive association to health. This positive effect can be seen in a range of results, most notably positive mental health in relation to the stress process (Koenig, McCullough, Larson 2001; Ellison and Levin 1998; Pargament, et al. 1998). Most previous studies have focused heavily on the outcomes and effects of religious coping or the

application of sociology to the stress process (Koenig, McCullough, Larson 2001; Pearlin 1989; Ellison and Henderson 2011). However, little research has been done in the field concerning the social factors that initially spur an individual to employ religious coping in relation to a life event stressor in the first place. Some people may be more likely to use it than others based on their social values.

Theoretical Model

This research aims to identify social factors that contribute to the likelihood an individual will utilize religion as a personal coping mechanism in response to a life event stressor and proposes there are three main factors that influence this likelihood:

1) An individual's level of religious capital. It is hypothesized here that an increase in religious capital will lead to an increase in the likelihood of using religious coping while at the same time indirectly reducing the effects of other stressors on health.

2) Pre-existence of chronic life strain stressors. An increase in chronic life strain stressors will increase the use of religion as a coping mechanism in response to the stressors. An increase in chronic life strain stressors will increase the use of religion as a coping mechanism in response to the stressors.

3) Access to alternative resources and methods. An increased availability of alternative methods and resources when it comes to dealing with one's health will lead to a decrease in use of religion as a primary coping mechanism as well as indirectly decrease the effect of other stressors on health.

The dependent variable of this study, religious coping, can be measured by the extent to which an individual seeks health and healing information from sacred scriptures as well as the frequency of their prayer. The theoretical model proposed for linking the three predictors of

religious capital, stressors, and alternative resources and methods to the outcome of an individual using religious coping can be found in Figure 1 and is discussed in more detail below.

Religious Capital

Religious capital is defined in this study as the culmination of an individual's investment in his or her faith tradition. It is also an umbrella term for various religious resources available both externally and internally to an individual. The selective engagement of these various resources by an individual encountering a life event stressor is a reflection of social values learned throughout the individual's life.

There are two main categories of resources available under the term religious capital, social support resources and intrapersonal resources. Social support resources deal with social integration and enacted social support, while intrapersonal resources deal with things such as self-esteem, personal efficacy, positive psychological traits, and coping styles (Ellison and Henderson 2011). Religion is an effective psychological resource of coping when emotion-regulation is the primary coping task, problem-solving approaches are ineffective, and/or worldly explanations are unavailable. Throughout the stress process, both the social support and intrapersonal nature of religion play a key role in the coping process.

Social support resources include "church-based support, specific religious coping responses, religiously-based feelings of control, prayer, and a religious sense of meaning in life" (Krause 2011: 207). Utilizing cross-sectional data from a national survey of immigrants to the United States, Shapiro (2011) concluded that amongst immigrants, the social support received from ethnic church communities was positively associated with better health among immigrants. Such resources intermix with the various coping styles encompassed in religious coping. As Park (2005: 723) concludes in her study on religion as a meaning-making device for coping with

stress, religious institutions not only provide support and structure (as noted by Krause) but they also "reinforce and facilitate the application of religious meaning systems by individuals when they are coping with stressful situations."

The variation in using the tool of religion in the coping process is also related to an individual's God concept and each concept's related style of religious coping. Religious coping can take a variety of forms based on an individuals' God concept. God concept is related to the way an individual is taught to view God – be it all-loving, all-powerful, vengeful, etc. These various God concepts, both a product of personal experience and religious tradition, affect the likelihood an individual employs religious coping and the style in which they use it. In general, Pargament, et. al (1998) found that positive religious coping lowered psychological distress, promoted spiritual growth, and higher levels of cooperativeness; in contrast, negative religious coping produced emotional distress, depression, greater psychological distress, and callousness towards others.

Previous research has also looked at the effect personal religious values have on the likelihood of an individual employing religious coping in relation to different situational stressors. Maynard, Gorsuch, and Bjorck (2001: 73) in their study on utilization of religious coping styles in various stressor situations concluded that "personal religious variables appear to play an important mediating role in the religious coping process" as individuals tended to not alter their religious coping style based on the type of stress situation (threat, loss, challenge) they were presented. Though not studied in depth, it was suggested this variation was related to personal participation levels in religion (Maynard, Gorsuch, and Bjorck 2001: 73). In contrast however, Schaefer and Gorsuch (1993: 146) found that the degree of religious coping did change according to situational factors and participants actually utilized God more in their coping style than was expected. However, neither of these studies looked at intrapersonal resources as being a

predictor variable for the use of religious coping in the first place, rather they assumed religion to be the independent variable.

This study is particularly interested in both social support resources as well as intrapersonal resources that are aspects of religious capital. It is important to look at both the social support mechanisms and intrapersonal resources of religious capital because both are intrinsic functions of religion. To only consider one function of religion in this study would not be advantageous in understanding the totality of how religious capital influences the use of religious coping. It is hypothesized that an increase in religious capital will lead to an increase in likelihood of utilizing religious coping. This can encompass various aspects of both intrapersonal resources and social support resources from a wider faith community. If an individual feels more invested in his or her faith, thus having increased religious capital, they are more likely to use this religious capital in other avenues of their life, such as dealing with life event stressors. At the same time, if an individual has greater religious capital, they are less likely to be as affected by other stressors in their life such as age and family and work burdens because they will utilize their religion to understand and deal with such stressors (Ellison and Henderson 2011; Krause 2011).

Religious capital can be measured in terms of religious service attendance, an individual's view of God, and their own degree of religiosity. Religious service attendance contributes to religious capital by increasing social support resources by constant contact with a faith tradition community as well as demonstrates a level of involvement to a faith tradition. An individual's certainty of belief in God and his or her own degree of religiosity are intrapersonal resources that contribute to overall religious capital. An individual's certainty of belief in God can affect the type of relationship they perceive having with God and the closeness or influence they believe God has on their daily life. Similarly, religiosity reflects the degree to which an

individual considers him or herself religious and thus defines the strength of connection to a religion. Religious capital, though seemingly the most obvious, is not the only predicting factor behind the use of religious coping when faced with a life event stressor.

Stressors

Various stressors in life can lead to an increase in the use of religious coping. The greater the increase in various stressors in life, the more likely an individual will employ religious coping in order to deal with these stressors. Though many stressors occur over the lifespan, this study is specifically interested in understanding stressors as being a result of an individual's subjective poorness of health, age, and his or her familial financial stress. These are chronic strains on an individual's life and thus when said individual is faced with a specific life event stressor, their likelihood of utilizing religious coping increases (Pearlin 1989). Poor health, increasing age, and stress resulting from concerns about family finances can be stressors that underlie and catalyze the use of religious coping when a life event stressor does present itself. However, these stressors can be mediated by religious capital, as discussed above, and through the availability of alternative methods and resources for dealing with them.

Alternative Methods and Resources

Alternative methods and resources is the third predictor in the likelihood an individual uses religious coping. Alternative methods and resources include such things as access to advanced medical procedures or knowledge of other effective treatments or coping mechanisms. The ability to access and use alternative methods and resources when dealing with a life event stressor decreases the likelihood an individual will utilize religious coping for dealing with it. If alternative methods and resources address the specific life event and subsequently remove the

stress of it or are more effective coping tools because they lead to the diminishment of the stressor, not just the ability to deal with its effects, they are going to be more favorable to an individual than simply a coping method, such as the use of religion, that can only deal with the effects of the stressor while doing little to alleviate the cause. At the same time, the knowledge and ability to use alternative methods and resources also leads to a decrease in the effect of other life stressors, as mentioned above.

Access and attainability of these alternative methods and resources when it comes to dealing with a life event stressor is usually precipitated by socioeconomic status. The higher an individual's socioeconomic status is, the more likely they will have the exposure, money, and knowledge to explore various different avenues for dealing with a life event stressor rather than turning to religion as a primary coping mechanism. Socioeconomic status can be measured through factors such as income and highest attained educational level. These factors play heavily into an individual's socioeconomic status which directly affects the availability of resources that are available to them to use in light of a life event stressor. The more options that are available and the more viable and effective they are in comparison to only using religious coping, the less likely such an individual will be to use religious coping in the first place.

Data and Methods

The data used in this study comes from the General Social Survey 2012 Cross-Section and Panel combined. The General Social Survey (GSS) is a biennially, natural survey conducted by the National Opinion Research Center (NORC). The 2012 GSS uses a combined repeating cross-section and panel-component design and has 4,820 total cases representative of the U.S population. It is specifically designed to collect social indicator research through the replication of questionnaire items and wording in order to study longitudinal trends.

The 2012 GSS has a range of questions that focus on various uses of religious scriptures, health concerns, emotional and physical health, financial independence, educational attainment, age, and income inequality, all factors practical in the ramifications of this study's research focus. Statistical analysis was used to understand the way in which different social factors as measured by variables in the GSS can predict the likelihood an individual employs their religion when dealing with health related concerns.

Measures

Outcomes

The outcome for the following analysis comes from two distinct questions asked on the GSS: "In the past year, to what extent did you read scripture to learn about attaining health or healing?" and "About how often do you pray?" In regards to use of scripture to learn about health and healing, respondents were first asked, "Within the last year, have you read the Bible, Torah, Koran or other religious scriptures, not counting any reading that happened during a worship service?" given response choices of either "yes" or "no." Only respondents who replied "yes" to the previous question were then asked follow up questions inquiring as to their use of scriptures in relation to different aspects of life, one being whether they had read scripture in the last year to learn about attaining health or healing. In regards the extent to which an individual reads scripture to learn about attaining health or healing, respondents could choose "not at all", "to a small extent", "to a moderate extent", "to a considerable extent", or "to a great extent." Though it is understood that this filter question in regards to extent to which individual's use scripture to learn about health and healing could preclude some individual's from this study as some may attain necessary levels of religiosity to be utilized as a coping mechanism while attending a public, organized service, the focus of this study is exclusively on private and

personal use of religious coping. Though it can be recognized that some may receive all necessary coping from organized religion, this study is interested in those who take it into their own hands outside of organized services. This study is interested in private, personal coping.

In regards to the question inquiring about frequency of prayer, the following choices were given: "never", "less than once a week", "several times a week", "once a day", or "several times a day." A study done by Baker (2008) found that those who most frequently prayed primarily used prayers of petition such as asking for God's influence on their personal health. Additionally, Hayward and Krause (2013) using a longitudinal study, found that as age increased, so did frequency of prayer for various types of prayer content, one being in regards to one's health. Therefore, frequency of prayer can be believed to relate in some way to the extent to which individuals think and utilize religion to address their problems, in particular health problems, thus a function of religious coping and a viable dependent measure for this study. These outcomes measure use of religious coping by the individual respondent. Exact coding for each of these measures can be found in Appendix A. Focus was then placed on the three concept categories identified by the theoretical model as being influential and predictive of the use of religion as a coping mechanism. These concepts were measured through the collection of direct measures as asked by the survey questions.

Predictors

There were three categories of predictors utilized in examining the outcome measures of this study: religious capital, stressors, and alternative methods and resources. These categories could be broken down into direct measures taken from the survey and understood to function through the theoretical pathways mapped out by this study.

Religious capital was measured through four distinct questions, encompassing religion's function as an intrapersonal as well as a social support mechanism. In regards to intrapersonal resources, respondents were asked, "Which statement comes closest to expressing what you believe about God?" and were given the following choices: "I don't believe in God", "I don't know whether there is a God, and I don't believe there is any way to find out", "I don't believe in a personal God, but do believe in a Higher Power of some kind", "I find myself believing in God some of the time, but not at others", "While I have doubts, I feel that I do believe in God", and "I know God really exists and I have no doubts about it." Additionally, to gage personal religiosity, respondents were asked "To what extent do you consider yourself a religious person?" with response options ranging from "not religious at all", "slightly religious", "moderately religious", to "very religious." Finally, as a measure of social support that can be built within religious capital, respondents were asked "How often do you attend religious services?" with the ability to respond "Less than once a year", "once a year", "several times a year", "one to three times a month", "nearly every week", and "every week or more." It is assumed that frequent attendance corresponds with interaction with fellow worshippers of a faith tradition and thus a building of social support within a religious context.

The second category of predictors theorized to be a pathway that influences the likelihood of utilizing religious coping are through stressors. Stressors in this study refer to chronic strains that occur in an individual's life such as his or her subjective poorness of health, age, and familial financial stress. In regards to subjective poorness of health, it was asked, "Would you say that in general your health is excellent, very good, good, fair or poor?" Additionally, the following question was asked in regards to familial financial stress: "So far as you and your family are concerned, would you say that you are pretty well satisfied with your present financial situation, more or less satisfied or not satisfied at all?" Though the above two

are arguably subjective measures, these variables give some insight into respondent's own perception of condition in and of life which is important in understanding their likelihood of employing a coping mechanism of any type. Finally, the age of each respondent was collected as demographic information.

The third and final category of predictors of use of religious coping is the ability an individual has to access and utilize alternative methods and resources for coping with their life event stressor. The feasibility and accessibility of these alternative resources can be measured by questions regarding an individual's income and education as collectively these two questions give a look into an individual's socioeconomic status. Respondents were asked, "In which of these groups did your family income, from all sources, fall last year before taxes, that is?" and they were given response categories ranging from, "under $1,000" to "$150,000 or over." In regards to education, respondents were asked, "Do you have any college degrees?" and given the choices to respond with "left high school", "high school", "junior college", "bachelor", or "graduate" degrees. Further coding for each of these measures can be found in Appendix A.

Controls

Additionally, controls such as gender, race, marital status, and religious tradition were included in the overall data analysis of this study. Gender, race, and marital status were re-coded from the original data set in a binary fashion. Therefore, each case could either be a 0 or 1 in each regards to each respective control variable category. Male was used as the reference for gender, those who identified as black or of another race were the reference group for race, and those who were unmarried (i.e. never been married, widowed, divorced, or separated) served as the reference group in terms of marital status. Protestantism was used as the reference group in relation to other generally accepted divisions among religious traditions (Idler, et. al 2003).

Previous literature suggests that the personal religiosity of an individual is more influential in the likelihood that they utilize religious coping than their specific religious tradition (Maynard, Gorsuch, and Bjorck 2001; Schaefer and Gorsuch 1993). Therefore, understanding religious tradition only in terms of reference is adequate for the ramifications of this study. Table 1 further illustrates the way each of the control variables were coded for the purposes of this study.

Results

I begin by examining some descriptive results. Figure 2 illustrates the extent to which people read scripture to learn about attaining health and healing. Although 43.7 percent of people report not at all reading scripture to learn about attaining health or healing in the last year, over half of all people report using scripture to some extent when it comes to learning about health or healing. Broken down, 9.1 percent of respondents reported using it to a great extent, 7.3 percent to a considerable extent, 19 percent to a moderate extent, and 21 percent reported using scripture to learn about health and healing to a small extent. Additionally, Figure 3 illustrates that almost half of all people, that is 48.2 percent, report praying several times a day. This is followed by 32.8 percent saying they pray once a day, 8.1 percent saying several times a week, 2.6 percent reporting once a week, 4.6 percent less than once a week, and only 3.7 percent saying they never pray. The data of both dependent measures of this study illustrate the prevalence of use of religion in daily life. Further analysis seeks to understand the way this use of religion for purposes of health and healing varies by different measures of religious capital, stressors, and alternative methods and resources.

In terms of religious capital, the degree to which an individual reported being a religious person and their extent of using scripture to a great extent to learn about attaining health or healing had a dramatic parallel as seen in Figure 4. 16.9 percent of people who reported being

very religious also said they used religion to a great extent to learn about health and healing. This was followed by 5 percent of those who identified as moderately religious, 6 percent of those who were slightly religious, and 8.5 percent of those who identified as not religious at all. As hypothesized in the theoretical model, those who are more religious and thus have more religious capital, were also likely to report using religious coping to a greater extent than those who are not.

In terms of stressors, both subjective poorness of health and age exhibited patterns of interest when it came to using scripture to learn about health and healing. Figure 5 illustrates the percentages of those who reported using scripture to a great extent to learn about health and healing by degree of their own reported subjective poorness of health. Of those who said their health was in excellent condition, only 11.6 percent said they used scripture to a great extent for health and healing. This is followed by 6.5 percent of those who said their health was very good, 7.5 percent who said their health was good, and 11.6 percent of those who reported only fair health saying they used scripture to a great extent for health and healing. However, over a quarter, 26.1 percent, of those who said their health was poor also said they used scripture to a great extent for learning about health and healing. As in the theoretical model and previous literature, Figure 5 illustrates that the poorer an individual's health is, the more likely they might be to say they use scripture to a considerable extent when seeking health or healing.

Figure 6 illustrates the way age affects the extent to which individuals use scripture for health or healing to a considerable amount. Contrary to the proposed method of influence, age does not have a linear effect on use of religion for health as those who are of middle age are actually most likely to use religious coping. Of those in the 18-29 year old age range, only 2.5 percent said they use scripture to a great extent for learning about health and healing, while 9.9 percent of 30-44 year olds do. However, the extent to which individual's use scripture for health

peaks at 12 percent with 45-59 year olds. This is followed by declining percentages in both the 60-74 year old group with 9.6 percent and for those who are 75 years old or older only 4.8 percent reporting they do so. This unexpected result is addressed in greater detail in the discussion part of this paper.

Thirdly, access to alternative methods and resources, as defined by socio-economic class, also influences the extent to which individuals used scripture to a considerable extent when dealing with health or healing. Figure 7 illustrates the relationship between highest educational degree earned and those who responded that they used scripture to a great extent when learning about health and healing. A quarter, 25 percent, of those who left high school reported using scripture to a considerable extent, 19.7 percent of those whose highest degree was high school, and 25.9 percent of those whose highest educational degree was junior college. However, a considerable drop in percentages ensues when looking at higher degrees. Only 15.6 percent of those with a bachelor's degree and 11.5 percent of those with a graduate degree reported using scripture to a great extent to learn about health and healing. This relationship supports the theoretical model in that those who are of a higher socio-economic class, as defined by wealth and education, are less likely to use religious coping.

Descriptive statistics for each variable that was then used in an ordinary least squares regression analysis can be found in Table 1. The first outcome variable, use of scripture to learn about attaining health or healing, had a range of 4 with a mean of 2.17 and a standard deviation of 1.308. The second outcome variable, frequency of prayer, had a range of 5 with a mean of 5.06 and a standard deviation of 1.292. As stated above, half of all people chose the maximum choice when it came to frequency of prayer. In terms of predictors, both religious service attendance and certainty of belief in God were measured on a range of 5 response categories. Religious service attendance had a mean of 4.23 and certainty of belief in God had a mean of

5.51 with most people believing in God and having some to no doubts. Religiosity had a range of 3 and a mean of 2.92. Subjective poorness of health and age had ranges of four with means of 2.72 and 2.93, respectively. Familial financial stress had a range of 2 and mean of 2.03. Income had a range of 5 and a mean of 3.06. The final predictor, education had a range of 4 and a mean of 1.71 with most people reporting high school as their highest degree. Looking at the control variables, in terms of gender, males were coded at 0 and females as 1. The mean for gender was 0.621 meaning there were slightly more females than males in the data set. In terms of race, black and all other races were coded as 0 and white was coded as 1. The mean for the control variable of race was 0.719 meaning there were slightly more whites than all other races included in the data. Marital status was re-coded so that 0 was equal to unmarried (i.e. never been married, widowed, divorced, or separated) and 1 was married. The mean for marital status was 0.457 meaning there were about equally as many married as unmarried individuals represented in the data set, though slightly more were unmarried. Finally, religious tradition was re-coded into Protestant, Catholic, other religion, and no religion. Of all respondents in this study, about 67 percent identified as being Protestant and 15 percent as Catholic. Those of other religions as well as those identifying as no religion both made up about 8 percent of respondents each.

Having looked at several descriptive analyses that draw upon measurable variables from the theoretical model, attention is now turned to the regression analyses. The ordinary least squares regression analyses assist in separating out the independent effects of measures of religious capital, stressors, and alternative methods and resources on the use of religious coping. The standardized coefficients for each variable are presented here. Table 2 contains the results of these analyses.

The first set of predictors measures religious capital. Religious service attendance had a statistically significant effect when it came to both the use of scripture to learn about attaining

health or healing as well as frequency of prayer. As an individual's religious service attendance increases so does their use of scripture to learn about attaining health or healing as well as his or her frequency of prayer. An individual's certainty of belief in God was only statistically significant when it came to frequency of prayer. The standardized coefficient indicates that as an individual's certainty of belief in the existence of God increases so does his or her frequency of prayer. A person's self-reported degree of religiosity was statistically significant when it came to looking at frequency of prayer and use of scripture for health or healing. Again, as a person's religiosity increases, so does his or her use religious coping. These results are all in accord with the pathway of the theoretical model that suggests increases in religious capital lead to greater likelihood of use of religion as a coping mechanism.

The second set of predictors measures various chronic strain stressors in daily life. Subjective poorness of health was the only statistically significant predictor found under this category and only in relation to use of scripture to learn about attaining health or healing. As an individual's health deteriorates, or becomes poorer, the less likely they are to use scripture to learn about attaining health or healing. This is contrary to the proposed effect health has on the use of religious coping as hypothesized by the theoretical model. This result will be further addressed in the discussion and conclusion portion of this paper.

The third and final set of predictors measures the availability of alternative methods and resources to dealing with a life event stressor which is primarily defined by one's socioeconomic status. Neither income nor education was found to be statistically significant in the influence of frequency of prayer or use of scripture to learn about attaining health or healing. The lack of statistically significant results in this set of predictors does not support the theoretical model in which access to alternative methods and resources leads to a definite decrease in the likelihood of use of religion as a coping mechanism.

Finally, control variables were added in order to understand the independent effects of gender, race, marital status, and religious tradition affiliation on use of religious coping. Females were statistically significantly more likely than males to pray more often. People who identified their race as white were statistically significantly less likely to use scripture to learn about health and healing in comparison to any other race. Being married had a statistically significant effect on use of scripture to attain health or healing with those being married less likely to do so than those who are unmarried. There was no statistically significant difference among various religious groups in relation to use of religious coping. However, those who reported as being of no religion were statistically significantly less likely to engage in prayer than Protestants.

Discussion and Conclusion

Stress is an inevitable aspect of life and learning to cope with significant life stressors is a part of being human. Though previous research has looked into the various ways individuals cope with such stressors, very little has been done looking into the social predictors that lead an individual to use a certain type of coping mechanism over another in the first place. This research illustrates that various social aspects can play a role in the likelihood an individual uses religious coping.

First, religious capital plays arguably the most influential role in determining whether an individual uses religious coping. The three measures of religious capital used in this study sought to collect the social support effects of religion as well as its function as an intrapersonal resource. Collectively, the greater the religious capital of an individual the more likely they are to use religious coping which supports the hypothesized effect of religious capital proposed by this study and as illustrated by the theoretical model. This also corresponds with the findings of previous studies that have shown personal religiosity as well as religious service attendance to be

correlated to one's condition of health overall (Koenig, McCullough, Larson 2001; Krause 2011; Pargament, et al 1988; Maynard, Gorsuch, and Bjorck 2001). Although religious capital was highly correlated with measures of religious coping, there are also other predictors that influence the overall likelihood an individual will utilize religion as a coping mechanism.

As the theoretical model illustrates, other chronic life strains can put stress on an individual that affects the use of coping. However, in contrast to the hypothesized positive effect of stressors, that is increasing the likelihood of using religious coping, the data of this study suggests that those who have greater chronic strains are not more likely to use religious coping. An individual's subjective poorness of health was only statistically significant when it came to measuring use of scripture to learn about health or healing and it had a negative correlation, that is, as health became poorer, people were actually less likely to turn to religious coping. This can further be complicated by looking at Figure 5 in which those who said their health was poor also reported using religious coping to the greatest extent, followed by those who said their health was excellent. This could be the product of the combination of those who are in the poorest of health being most likely to use religious coping, but those who are of better health conditions seeking the council of religion for purposes other than coping, not accounted for in this study. Those in excellent health may consult religion in thanksgiving or in further assistance of good health. Park (2005) found that religion was often positively related to subjective well-being and thus religion can be employed in a positive meaning-making strategy. This could allude to those in generally good health employing religion in relation to their lives in a positive fashion and not just those who identified their health as poor utilizing religion as a coping mechanism thus leading to the nonlinear results found in this study.

Additionally, though it was hypothesized that as age increases, so too would use of religion as a coping mechanism, this was not fully supported by the results of this study. Though

as age increases, there is a slight positive increase in use of religious coping, this was not statistically significant. In this study, age and use of religious coping had a non-linear relationship. Those who were middle-aged (between 45-59 years old) were actually the most likely age group to use religious coping rather than the most elderly. The effects of age may be the product of an individual more or less accepting their condition with time. An individual who feels that they are middle-aged and should not be experiencing such a life event stressor may be more likely to seek coping and resources to handle it. However, an individual who is 75 years old or older may be more likely to mentally accept their condition as a part of the life cycle and be less likely to seek out resources to deal with it, thus being less likely to use religious coping. However, it should be noted that age was coded on a spectrum for the purposes of this study so there is the potential that dummy coding of different ages could be used to test for the nonlinearity of age's influence on use of religious coping. This could lead to a better understanding of the complete relationship between age and religious coping by taking into account within age group variations that could have affected the overall relationship between age and religious coping that appears in the results of this study.

As far as access to alternative methods and resources, it was hypothesized that the higher one's income or education is, thus a measure of higher socioeconomic status, the less likely he or she was to use religious coping. Though none of the values in this category were found to be statistically significant, they all had a negative coefficient in that as they increased, the likelihood of using religious coping decreased. However, definite support for this study's theoretical model cannot be ascertained from these results.

Finally, females were more likely to say they engaged in prayer, which is to be expected as females consistently show to be more religious than males in various studies (Koenig, McCullough, and Larson 2011; Ellison and Levin 1998; Kilbourne, Cummings, and Levine

2001). At the same time, those with no religion were least likely to say they engaged in prayer, which is an intuitive result. Those who profess no religion are also least likely to engage in religious-related activities, such as prayer. Those who are white or married are also among those who are less likely to say they have used scripture to learn about attaining health or healing. These results suggest that those who are marginalized, such as those of racial minorities, may be more likely to employ religious coping. Though no definite conclusion can be drawn from the results of this study alone, these demographic trends could be a result of these groups having fewer alternative and accessible coping strategies or the belief that religious coping is in fact more efficacious in relieving their stress related to their life event stressor. Shapiro (2011) found in his study of immigrant health that organized religion provided a social support network for immigrants facing health issues and who felt they had few other resources to turn to for help.

Though this research helps shed light on background societal elements that help in understanding and predicting the likelihood an individual will employ religious coping in the first place, it does have certain limitations. First, it should be remembered that a filtering question was used to attain one of the dependent measures of this study. If the filtered out respondents to the survey had been used in the end analysis, the overall sample size would have decreased and significant recoding of variables would have ensued. Utilizing a survey in which this would be a none-issue would increase the total sample size. Additionally, use of religious coping was measured by two different variables in this study. However, as mentioned previously, neither measured variable could differentiate whether religion was used in response to a negative event and thus specifically only as a coping mechanism, or if it was used by an individual in other capacities such as for thanksgiving or for consultation of improving an already favorable condition of health. As far as future research is concerned, further interest may be placed in investigating the effects of religious capital as a predictor of religious coping. This study sought

to be inclusive of all effects religion may have on the dependent variable, that is both intrapersonal resources as well as social support mechanisms that stem from religious capital, while future research may be interested in further dissecting this predictor and determining which specific functions of religion are most influential on a person's likelihood of using religion as a coping mechanism.

This study looked at religion as a dependent variable and focused on the social factors that influence the likelihood an individual will utilize religious coping in relation to a life event stressor. Religious capital was found to have a strong positive influence when it came to using religious coping. This result supports the hypothesized theoretical model of correlation. Alternatively, access to alternative resources and methods as a facet of socioeconomic status did not have a statistically significant relationship to the likelihood of using religion as a coping mechanism. Other life stressors such as age, subjective poorness of health, and familial financial stress had mixed and contrary results to that of the theoretical model. These results may be due to the aging process and acceptance of one's condition in life. This study's results have the potential to lead to more comprehensive patient care as they illustrate the way in which understanding an individual's social background can help one understand the modes of coping that might be most useful or desired by a given individual.

Bibliography

Baker, J. O. (2008). An investigation of the sociological patterns of prayer frequency and

content. *Sociology of Religion, 69*(2), 169-185.

Blasi, A.J. (2011). The recondite religious life of health. In A.J. Blasi (Ed.), *Toward a*

Sociological Theory of Religion and Health: Religion and the Social Order – An Official

Publication of the Association for the Sociology of Religion, Volume 19 (Ed. W.H.

Swatos, Jr.). (pp. 261-271). Leiden, the Netherlands: Brill.

Ellison, C.G., and Henderson, A.K. (2011). Religion and mental health: through the lens of the

stress process. In A.J. Blasi (Ed.), *Toward a Sociological Theory of Religion and Health:*

Religion and the Social Order – An Official Publication of the Association for the

Sociology of Religion, Volume 19 (Ed. W.H. Swatos, Jr.). (pp. 11-44). Leiden, the

Netherlands: Brill.

Ellison, C.G., and Levin, J.S. (1998). The religion-health connection: evidence, theory, and

future directions. *Health, Education, and Behavior*, 25, 700-720.

Hayward, R. D., and Krause, N. (2013). Patterns of change in prayer activity, expectancies, and

contents during older adulthood. *Journal for the Scientific Study of Religion, 52*(1), 17-

34.

Idler, E.L., Musick, M.A., Ellison, C.G., George, L.K., Kraus, N., Ory, M.G., Pargament, K.I.,

Powell, L.H., Underwood, L.G., and Williams, D.R. (2003). Measuring multiple

dimensions of religion and spirituality for health research: conceptual background and findings from the 1998 general social survey. *Research on Aging*, 25, 327-365.

Jacobson, C.F. Jr., Luckhaupt, S.E., Delaney, S., and Tsevat, J. (2006). Religio-biography, coping, and meaning-making among persons with HIV/AIDS. *Journal for the Scientific Study of Religion*, 45, 39-56.

Kilbourne, B., Cummings, S., and Levine, R.S. (2011). Does religion protect against psychological distress among chronically ill and poor women? In A.J. Blasi (Ed.), *Toward a Sociological Theory of Religion and Health: Religion and the Social Order – An Official Publication of the Association for the Sociology of Religion, Volume 19 (Ed. W.H. Swatos, Jr.).* (pp. 95-114). Leiden, the Netherlands: Brill.

Koenig, H.G., McCullough, M.E., and Larson D.B. (Eds.). Definitions. *Handbook of Religion and Health*. (2001). New York: Oxford University Press. 17-23.

Koenig, H.G., McCullough, M.E., and Larson D.B. (Eds.). Religion's negative effects. *Handbook of Religion and Health*. (2001). New York: Oxford University Press. 60-77.

Koenig, H.G., McCullough, M.E., and Larson D.B. (Eds.). Religion's positive effects. *Handbook of Religion and Health*. (2001). New York: Oxford University Press. 53-59.

Koenig, H.G., McCullough, M.E., and Larson D.B. (Eds.). Religious coping: the patient's

    experience. *Handbook of Religion and Health*. (2001). New York: Oxford University

    Press. 78-94.

Koenig, H.G., McCullough, M.E., and Larson D.B. (Eds.). Understanding religion's effects on

    mental health. *Handbook of Religion and Health*. (2001). New York: Oxford University

    Press. 214-228.

Koenig, H.G., McCullough, M.E., and Larson D.B. (Eds.). Understanding religion's effects on

    physical health. *Handbook of Religion and Health*. (2001). New York: Oxford University

    Press. 382-394.

Krause, N. (2011). Stress, religious-based coping, and physical health. In A.J. Blasi (Ed.),

    Toward a Sociological Theory of Religion and Health: Religion and the Social Order –

    An Official Publication of the Association for the Sociology of Religion, Volume 19 (Ed.

    W.H. Swatos, Jr.). (pp. 207-237). Leiden, the Netherlands: Brill.

Levin, J.S. (1994). Religion and health: is there an association, is it valid, and is it causal? *Social*

    Science and Medicine, 38, 1475-1482.

Marks, L. (2005). Religion and Bio-psycho-social health: a review and conceptual model.

    Journal of Religion and Health, 44, 173-186.

Maynard, E.A., Gorsuch, R.L., and Bjorck, J.P. (2001). Religious coping style, concept of God, and personal religious variables in threat, loss, and challenge situations. *Journal for the Scientific Study of Religion*, 40, 65-74.

Nash, S.T. (2006). The changing of the gods: abused Christian wives and their hermeneutic revision of gender, power, and spousal conduct. *Qualitative Sociology*, 29, 195-209.

Pargament, K.I., Smith, B., Koenig, H., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37, 711-725.

Park, C.L. (2005). Religion as a meaning-making framework in coping with life stress. *Journal of Social Issues*, 61, 707-729.

Pearlin, L.I. (1989). The Sociological Study of Stress. *Journal of Health and Social Behavior* 30, 241-256.

Schaefer, C.A., Gorsuch, R.L. (1993). Situational and personal variations in religious coping. *Journal for the Scientific Study of Religion*, 32, 136-147.

Schieman, S. and Bierman, A. (2011). The role of divine beliefs in stress processes. In A.J. Blasi (Ed.), *Toward a Sociological Theory of Religion and Health: Religion and the Social Order – An Official Publication of the Association for the Sociology of Religion, Volume 19 (Ed. W.H. Swatos, Jr.).* (pp. 45-68). Leiden, the Netherlands: Brill.

Shapiro, E. (2011). Religious involvement and Latino immigrant health. In A.J. Blasi (Ed.),

Toward a Sociological Theory of Religion and Health: Religion and the Social Order –

An Official Publication of the Association for the Sociology of Religion, Volume 19 (Ed.

W.H. Swatos, Jr.). (pp. 175-205). Leiden, the Netherlands: Brill.

Appendix A: Coding used for Outcome and Predictor Variables Used in Determining the Likelihood an Individual Uses Religion as a Coping Mechanism

Variables	Coding Used
Outcomes	
Use of Scripture to Learn about Attaining Health or Healing	1 = Never
	2 = Less than once a week
	3 = Once a week
	4 = Several times a week
	5 = Once a day
	6 = Several times a day
Frequency of Prayer	1 = Not at all
	2 = To a small extent
	3 = To a moderate extent
	4 = To a considerable extent
	5 = To a great extent
Predictors	
Religious Service Attendance	1 = Less than once a year
	2 = Once a year
	3 = Several times a year
	4 = One to three times a month
	5 = Nearly every week
	6 = Every week or more
Certainty of Belief in God	1 = I don't believe in God
	2 = I don't know whether there is a God, and I don't believe there is any way to find out
	3 = I don't believe in a personal God, but do believe in a Higher Power of some kind
	4 = I find myself believing in God some of the time, but not at others
	5 = While I have doubts, I feel that I do believe in God
	6 = I know God really exists and I have no doubts about it
Religiosity	1 = Not at all religious
	2 = Slightly religious
	3 = Moderately religious
	4 = Very religious
Subjective Poorness of Health	1 = Excellent
	2 = Very good
	3 = Good
	4 = Fair
	5 = Poor

Age   1 = 18-29 years old
2 = 30-44 years old
3 = 45-59 years old
4 = 60-74 years old
5 = 75 or older

Familial Financial Stress 1 = Satisfied
2 = More or less satisfied
3 = Not at all satisfied

Income   1 = $0-9,999
2 = $10,000-39,999
3 = $40,000-59,999
4 = $60,000-89,999
5 = $90,000-149,999
6 = $150,000 or over

Education   1 = Left high school
2 = High school
3 = Junior college
4 = Bachelor
5 = Graduate

Figure 1: Proposed Process Affecting the Likelihood an Individual Uses Religion as a Coping Mechanism in Response to Life Event Stressors
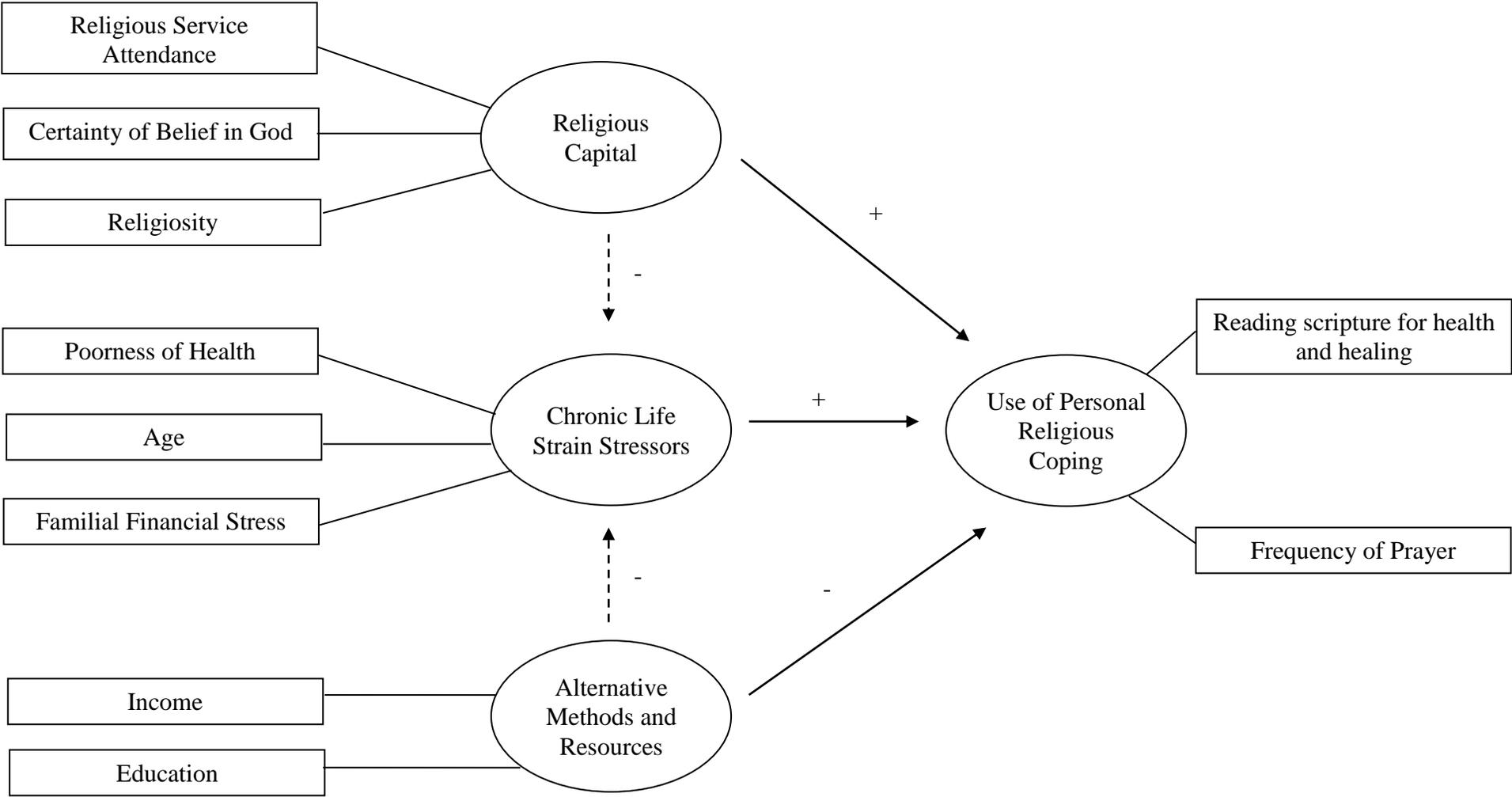
Figure 2: Percentages of Extent to Which People Read Scripture to Learn about Attaining Health or Healing
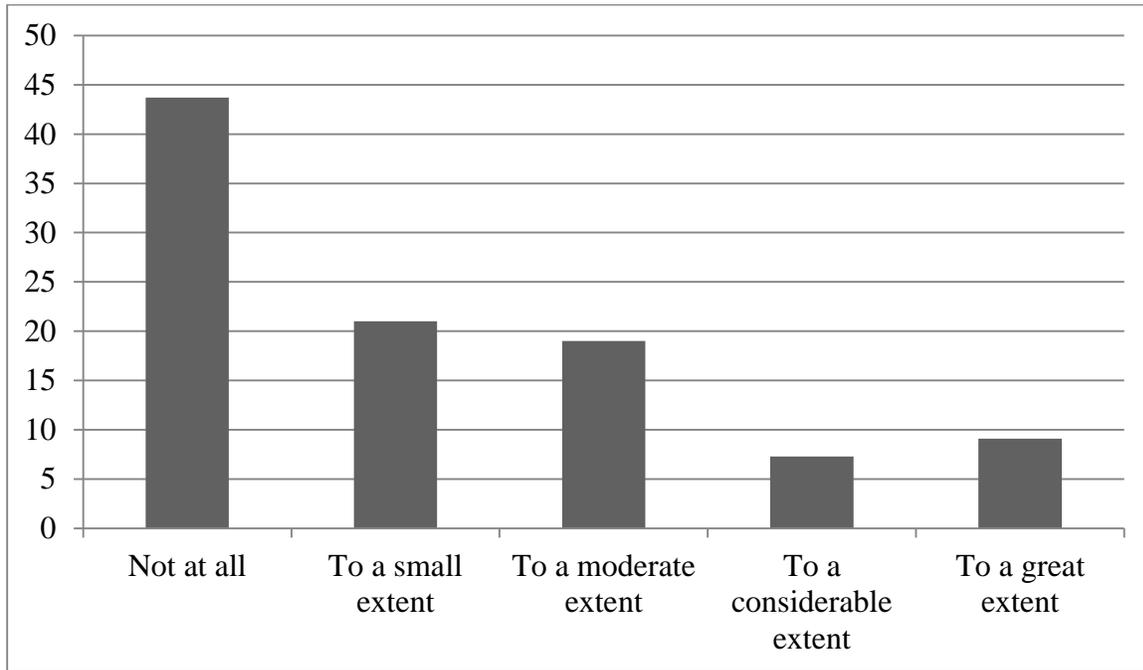

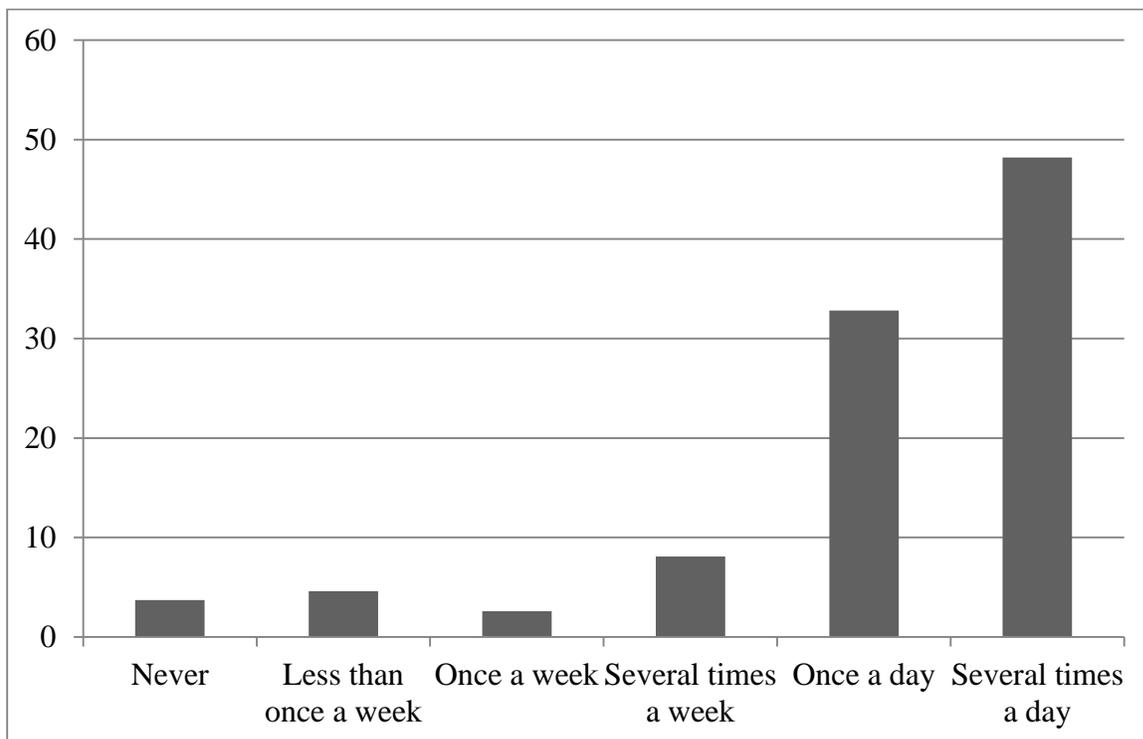**Figure 3: Percentage of Frequency of Prayer**

**Figure 4: Percentage of Those Who Use Scripture to a Great Extent to Learn about
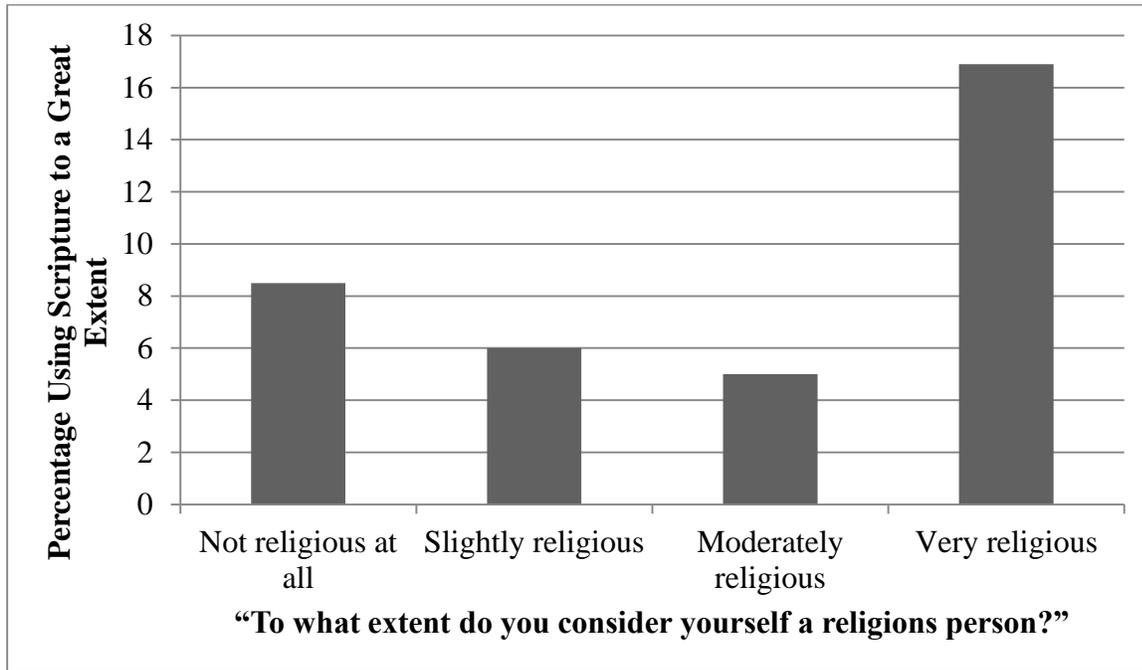Attaining Health or Healing by the Religiosity of the Person**

"To what extent do you consider yourself a religions person?"

**Figure 5: Percentage of Those Who Use Scripture to a Great Extent to Learn about
Attaining Health or Healing by Subjective Poorness of Health**

**"Would you say that in general your health is excellent, very good,
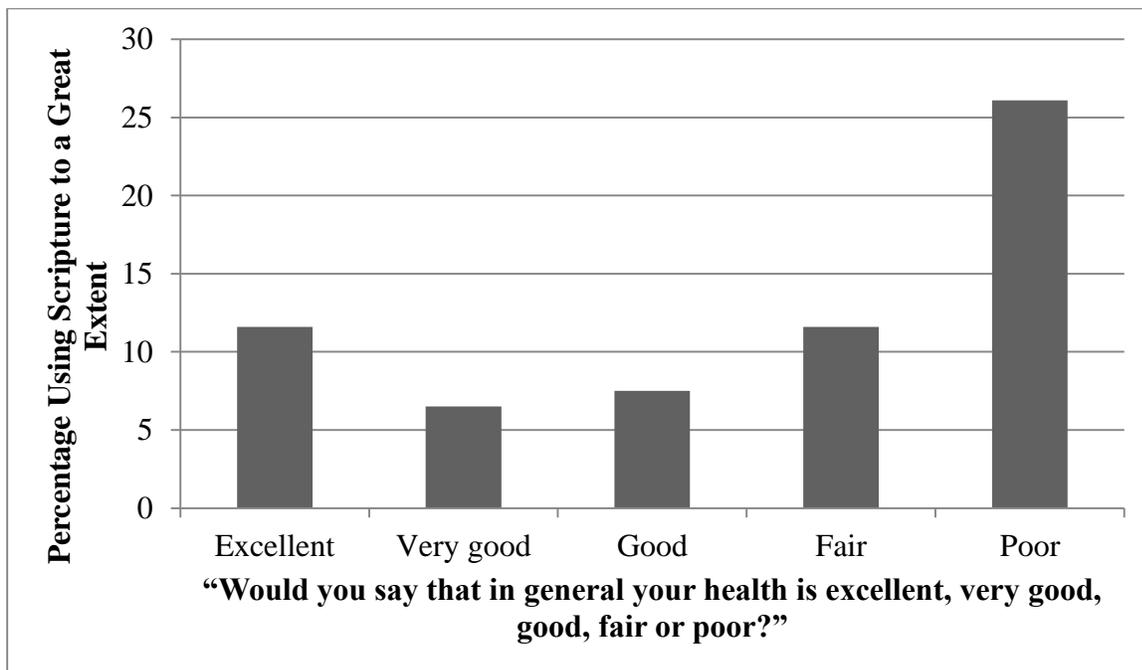good, fair or poor?"**

Figure 6: Percentage of Those Who Use Scripture to a Great Extent to Learn about Attaining Health or Healing by Age
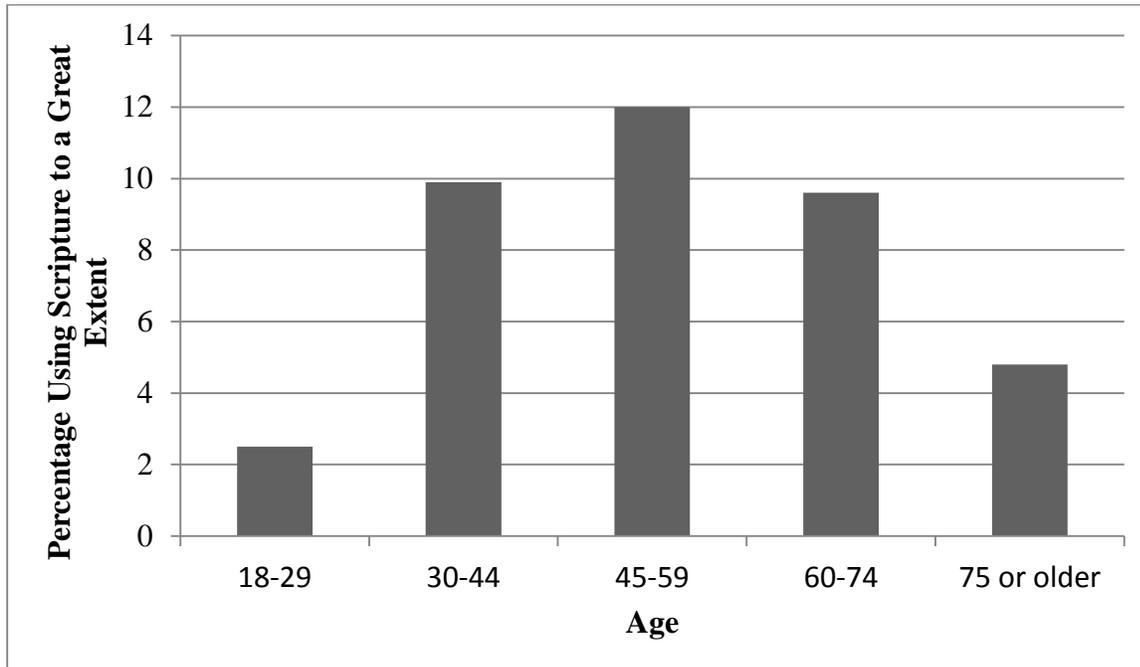

Figure 7: Percentage of Those Who Use Scripture to a Great Extent to Learn about Attaining Health or Healing by Highest Degree Attained
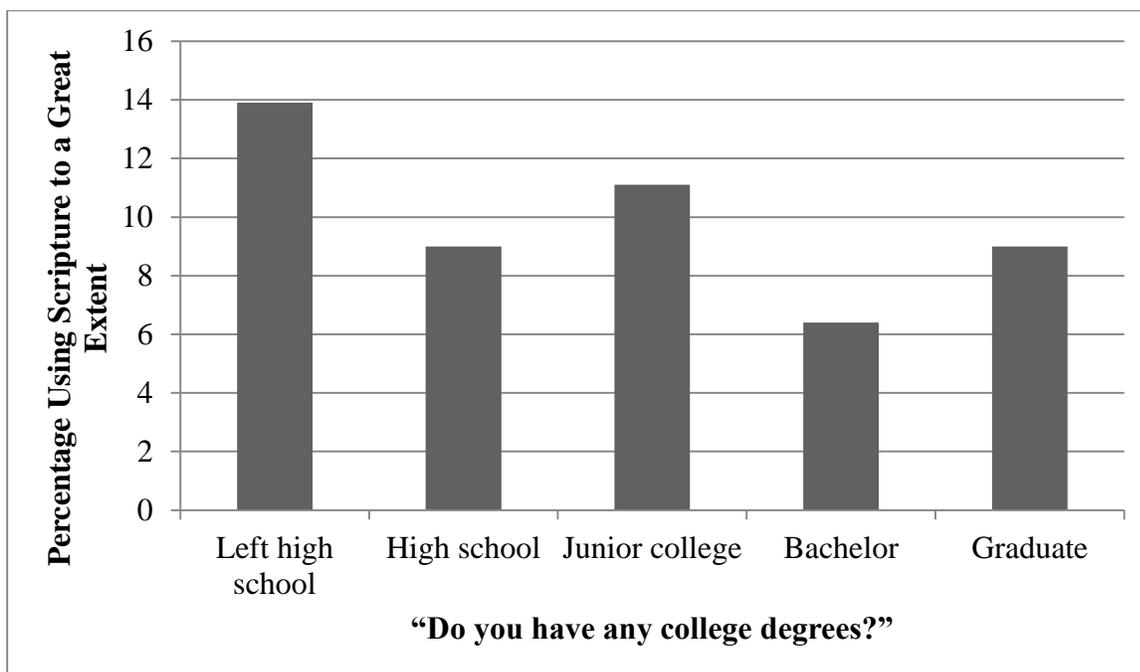
Table 1: Descriptive Measures of Variables and Controls Used in Determining the Likelihood an Individual Uses Religion as a Coping Mechanism (N=701)

	Range	Minimum	Maximum	Mean	Standard Deviation
Outcomes					
Use of Scripture to Learn about Attaining Health or Healing	4	1	5	2.17	1.308
Frequency of Prayer	5	1	6	5.06	1.292
Predictors					
Religious Service Attendance	5	1	6	4.23	1.886
Certainty of Belief in God	5	1	6	5.51	1.101
Religiosity	3	1	4	2.96	0.923
Subjective Poorness of Health	4	1	5	2.72	1.032
Age	4	1	5	2.93	1.145
Familial Financial Stress	2	1	3	2.03	0.775
Income	5	1	6	3.06	1.430
Education	4	0	4	1.71	1.218
Controls					
Female	1	0	1	0.621	0.486
White	1	0	1	0.719	0.450
Protestant	1	0	1	0.676	0.468
Catholic	1	0	1	0.157	0.363
Other Religion	1	0	1	0.080	0.271
No Religion	1	0	1	0.087	0.282
Married	1	0	1	0.457	0.498

Table 2: Ordinary Least Squares Regression Analysis of Predicting Factors Affecting Use of Religion as a Coping Mechanism in Response to Life Event Stressors (N= 701)

	Use of Scripture to Learn about Attaining Health or Healing	Frequency of Prayer
	Std. Coef.	Std. Coef.
Religious Capital		
Religious Service Attendance	.185**	.214**
Certainty of Belief in God	.056	.306**
Religiosity	.107*	.075*
Chronic Life Strain Stressors		
Subjective Poorness of Health	-.103**	.002
Age	.006	.058
Familial Financial Stress	.014	.015
Alternative Methods and Resources		
Income	-.065	-.067
Education	-.074	-.020
Controls		
Female	-.025	.140**
White *(ref: black/other race)*	-.247**	-.031
Married *(ref: unmarried)*	-.080*	.024
Religious Tradition *(ref: Protestant)*		
Catholic	-.042	-.041
Other religions	.061	.018
No religion	.044	-.196**

* $p < 0.05$ **$p < 0.01$