Religious Coping: A Remedy for Stress and Sorrows: Research into the efficacy and use of religious coping strategies among Protestants and Catholics in the West experiencing a serious medical condition

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Research into the efficacy and use of religious coping strategies among Protestants and Catholics in the West experiencing a serious medical condition

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Abstract

Each individual has their own way of dealing with a stressful situation. Research into the concept of religious coping provides insight into how Catholics and Protestants use their religious beliefs to deal with these types of situations. This thesis focuses on the use and efficacy of religious coping by Protestants and Catholics in the West experiencing a serious medical condition. This is an important topic because studying the relationship between religious coping and distress also shows what beliefs can be helpful or harmful during these situations. It also provides insight into the ways that these religious traditions influence the behavior of individuals whilst experiencing negative life events. The goal of this thesis is to identify the similarities and differences between the use of religious coping among Protestants and Catholics in the West experiencing a serious medical condition. In order to do this the thesis compares three studies on religious coping among Protestants and Catholics in the West. The results of this comparison suggest there are more similarities than differences in the use of religious coping between both groups. However, the efficacy of religious coping appears to differ between the groups. By looking at the core beliefs of the religious traditions this thesis offers possible explanations for these findings. This thesis revealed that the focus of Protestantism on faith as opposed to the Catholic focus on confession could be the reason why Protestants experience more benefits from religious coping in uncontrollable stressful situations. These findings should inspire future researchers to investigate the relations between religious coping and specific religious traditions.

Introduction

Throughout history there have been many discussions about the influence of religion on the psychological health of a believer. Some scholars believe it to be the cause of psychological distress, while others emphasize the possible benefits of religion to psychological health. In the last three decades scholars have made serious efforts to acquire and categorize data on the possible effects of religion on psychological health during stressful times. This field of research has resulted in the emergence of a new concept known as religious coping, which describes the process of individuals dealing with personal struggles by appealing to religious ideas and practices. This thesis aims to discover how Protestants and Catholics in the West use religious coping to deal with personal struggles. Although both are Christian traditions, research suggests that there are significant differences in how stressful events are handled. Therefore this thesis seeks to answer the following research question:

What are the similarities and differences in the use and efficacy of religious coping among Protestants and Catholics in the West dealing with a serious medical condition, and how can these be accounted for?

The current research on religious coping provides useful insights on this matter, because it reveals the ways in which religion is used by different people to deal with stressful situations such as medical illness. Although a significant amount of data on this topic has been collected over the past 30 years, scholars are reluctant in providing explanations of the differences between how Protestants and Catholics use religious coping. The complexity of the task at hand may very well account for this, as there are a multitude of factors that must be considered while engaging in a comparison of this magnitude. One important factor is that all aspects of religion

are influenced by their cultural environment. There is a difference between Catholicism in the Netherlands and in Brazil, which is why it is hard to make general claims about a religion.

In order to answer the research question, this thesis will address four sub-questions. 1) What are the similarities and differences in how Protestants and Catholics deal with a serious medical condition? 2) What are the similarities and differences in the efficacy of religious coping among Protestants and Catholics dealing with a serious medical condition? These two questions will be answered by examining three studies on religious coping, of which two were conducted in the US and one in Germany. 3) How can the differences in core beliefs of Protestantism and Catholicism explain these findings? It will be argued that the differences in the efficacy on religious coping can possibly be explained by the differences between the two religious traditions. 4) How do these findings on religious coping contribute to the field of religious studies?

The first chapter of the thesis consists of a literature review, which describes the relevant existing academic work related to the research question. The first chapter begins with a brief discussion on how the field of psychology has viewed the relationship between mental health and religion. The findings of Kenneth Pargament and other scholars on religious coping, a concept which emerged from the field of psychology in the 1990s will be discussed. By explaining this concept it will be clear that research shows that religion can have both a positive and negative effect on an individuals coping process. Researchers use religious coping measurement scales in order to categorizes the methods of religious coping used by people in stressful situations. Different religious coping strategies and their effects on the health of individuals will be discussed by looking at the existing research on religious coping. The end of this chapter dives into the research that report findings on different religious traditions.

The second chapter of the thesis will include the methodology used to conduct this research. This will include the research design, implications and limitations of this research and explains how a comparison of the chosen studies allows me to answer the research question. Results of these studies show the differences in how these individuals deal with personal crisis.

Chapter three of this thesis consists of a research analysis that examines the studies of Alferi et al. (1999), Zwingmann et al. (2008) and Tix & Frazier (1998). These three studies investigate religious coping among Protestants and Catholics who are experiencing a serious medical condition. This analysis shows how the studies are conducted, what methods were used and the results. At the end of each analysis the implications and limitations of the research will be discussed.

In the fourth chapter the studies will be compared with each other. It compares the demographics and the methods used by each study and discusses how these can possibly influence the findings. The results of the studies are compared with eachother, which show that religious coping is related to lower levels of distress for Protestants. In an attempt to explain these findings the differences in the core beliefs of Protestants and Catholics will be discussed. This involves examining the difference between *sola fide* and faith and works, and the authority of the church versus the authority of the person.

I will conclude that this thesis by stating that Catholics and Protestants mostly use the same religious coping strategies. The efficacy of religious coping is higher for Protestants experiencing a medical condition than for Catholics. Because the findings of the German study did not support this it is likely that cultural differences are important to consider for future research on religious coping.

Chapter 1 Literature Review

1.1 Religion from a psychological perspective

Psychiatrists have argued for both the positive and the negative side of the impact that religion can have on an individuals mental health when experiencing a personal crisis. Sigmund Freud was well known for his negative view of religion as he compared religious rituals with a form of obsessive neurosis (Freud, 1907). According to Freud there is a sense of guilt present in individuals with obsessive behavior that is similar to how the believer feels guilty for being a sinner (Freud, 1907). Another psychotherapist who had a negative opinion on religion is Albert Ellis. In *The Case Against Religion* (1962) Ellis argues that religion is detrimental to a persons mental health, because the believer will always be uncertain if his sacrifices of self-interest will be enough to please their god (Ellis, 1962). Religion can also reduce the use of reason, because it requires supernatural thinking and faith in the unempirical. Understanding religion this way, the religious person is less likely to deal with a personal crisis succesfully. There are also psychiatrists who view the relationship between religion and mental health in a positive light. In the last three decades the field of psychology became increasingly interested in the idea of religion having a positive impact on the mental health of someone who is going through a personal crisis. These discussions resulted in the emergence of the concept of religious coping.

1.2 Defining religion and coping

Psychology professor Kenneth Pargament is arguably the most influential scholar on the topic of religious coping, which is why this thesis will utilize his definition of religious coping. In *the psychology of religion and coping* (1997) Pargament discusses different perspectives on religion, coping and the relationship between both concepts. In order to understand what

religious coping means it is necessary to explain how Pargament understands religion and coping.

In his attempt to provide a definition of religion, Pargament makes a distinction between substantive and functional definitions. A substantive definition of religion focuses on the ‘‘beliefs, practices, feelings, or interactions in relation to a greater being.’’ (Pargament, 1997, p 25). The advantage of such a definition is that it represents the way in which people talk about religion in general. However, because it is a fairly broad definition, it risks to include a wide range of everyday practices. A functional definition of religion focuses on the function religion has for the individual, for example; ‘‘dealing with fundamental problems of existence.’’(Pargament, 1997, p 27). The problem with a functional definition is that it is at risk to reduce religion to the psychological function it fullfills for the individual, or society as a whole. Pargament bridges the substantive and functional definitions into one.

> ‘‘From the substantive tradition we take the sacred and from the functional tradition we generate the notion of a search for significance. Religion lies at the intersection of the two.’’ (Pargament, 1997, p 29-30)

Pargament defines ‘‘religion as a process, a search for significance in ways related to the sacred.’’(Pargament, 1997, p 32). The search for significance refers to how people live their life in a meaningful way, orienting themselves towards a certain goal. This search is directly related to the sacred, which according to Pargament is ‘‘a concept that includes the divine and the beliefs, practices, feelings, and relationships associated with the divine.’’(Pargament, 1997, p 31). This idea of the sacred is specific but also somewhat problematic, as there are many things that people consider to be sacred without being related to the divine. Although Pargament

is aware that it is impossible to provide a definitive definition of religion, this definition allows him to illustrate the relationship between religion and coping.

Pargament defines coping as ‘‘a search for significance in times of stress.’’ (Pargament, 1997, p 90). When experiencing stress, the individual searches for ways to make sense of their situation and perform actions that are aimed towards achieving the desired result. The coping process is different for everyone, because every individual deals with a situation in a unique way. Now that Pargament’s definitions of religion and coping are explained, it is time to describe how religious coping works.

1.3 Forms of religious coping

Religious coping occurs when individuals experience a personal crisis and deal with it by appealing to religious convictions. It therefore combines the search for significance in coping with a personal crisis to the sacred. Examples of religious coping are engaging in prayer to ask for guidance, finding support in talking to clergy and other church members or trying to find comfort in holy texts. In his research Pargament has identified three different methods of religious coping that differ in the way personal responsibility applies to the individual in the coping process. (Pargament, 1997, p 181)

In the self-directing approach the individual aims to take control over the personal crisis by relying on himself, instead of expecting a greater being to solve it. The individual who uses this approach beliefs that God has equipped people with all the tools to solve their problems. This style is related to higher levels of self-control and has shown to be effective in situations which require control. To no suprise individuals who use this approach have been shown to have high self esteem and problem solving skills. However, in the face of uncontrollable stressful situations such as illness, this style results in negative outcomes to the individuals health.

In the second approach called deferring, individuals seek to control the situation by placing the responsibility in the hands of a greater being. It is in God's hands how the situation plays out, which means that the individual has no direct control of the situation. This style can be beneficial in situations in which one must let go of control and is less effective in situations where it is required. Research has shown that individuals who use this approach have lower self esteem and problem solving skills.

Then there is the collaborative approach, which occurs when the responsibility in the coping process is shared by the individual and God on a somewhat equal basis (Pargament, 1997, p 181-183). By using this approach the person communicates with God through prayer, asks for guidance to succesfully deal with the situation and most importantly, collaborates with God to conquer the ordeal. The approach taken by the individual to cope with a stressful event, influences the likelihood of a positive or negative outcome in terms of psychological, physiological and spiritual health. Out of all the stressful situations that have been studied, the collaborative approach appears to be the most balanced out of the three, as it's produced the most consistent positive results. (Pargament,1997)

1.4 Measuring religious coping

Religious coping is best understood as a double-edged sword: it can have a positive or negative effect on a person. However, people can use a variety of coping mechanisms when experiencing a personal crisis. Together with his colleagues Pargament has developed the Brief RCOPE scale, which contains different religious coping methods and aims to provide researchers with a better understanding of the relationship between individuals, their religion and coping process during negative events (Pargament, 1997, p 298-299).

This scale is divided into two subscales containing 14 items related to positive and negative religious coping. Items that are found in the positive subscale consists of asking for

God's help to remove anger, asking for sins to be forgiven and trying to establish a stronger bond with the divine (Pargament et al., 2011, p 56). In the subscale of negative religious coping, statements such as believing to be punished by God, thinking it's the devils work, reappraising God's love and powers are found (Pargament et al., 2011, p 56). The difference between positive and negative religious coping is characterized by how secure the relationship between the individual and the divine is, in which positive religious coping indicates a more secure relationship with the divine and the latter an insecure one. How a person chooses to deal with a stressful event is important, because the use of positive or negative religious coping affects the psychological health of a person. (Pargament, 1997)

Researchers have developed more ways to measure religious coping besides the BRIEF RCOPE, because the items in the scale were focused too much on Christian ideas. In order to be able to measure religious coping in non-western religious traditions, scales such as the BARCS (Brief Arab Religious Coping Scale) were developed to measure Islamic religious coping (Abu-Raiya & Pargament, 2015). Items in this scale are oriented specifically towards Islamic ideas and practices. This thesis will focus on the research that uses the BRIEF RCOPE and other Christian oriented measurement scales, because of it's focus on the Protestant and Catholic traditions.

1.5 Effectiveness of religious coping

In 2011 research was done to gather all the results that Brief RCOPE had produced, which included a total of 30 studies using this model (Pargament et al., 2011). The studies included a total of 5835 participants and the majority of these studies were performed in the USA and Western Europe. The results have shown that positive religious coping was related to a positive psychological health and well being. The opposite is true for negative religious coping, which is related to a decrease in psychological health expressing itself in increased symptoms of depression and anxiety (Pargament et al., 2011).

So what are some of the health implications that are documented in relation to positive and negative religious coping? It was found that positive religious coping is related to a decrease in depressive and anxiety symptoms, lower degrees of experienced distress and increased happiness (Abu-Raiya & Pargament, 2015). Besides these psychological effects of positive religious coping, there is also evidence that suggests a beneficial effect on physical health. Studies on groups of HIV-positive patients found that spirituality can contribute to slowing down the progression of the illness.

> ‘‘Furthermore, the spiritual belief that “God is merciful” was protective of health over time, whereas the belief that “God is judgmental and punishing and is going to judge me harshly some day” was associated with a faster deterioration of CD4+ cells and poorer control of the HIV virus (21). Thus, view of God may be either helpful or harmful, depending on the nature of that belief.’’ (Ironson & Hayward, 2008, p 547)

The research suggests that positive religious coping is not limited to the psychological health of a person, but may also positively affect the physical health. This is also the case with negative religious coping, which are related to increased symptoms of anxiety and depression, feeling exhausted and can even serve as a predictor of mortality (Abu-Raiya & Pargament, 2015).

It is important to note that the effectiveness of religious coping differs between groups of people. The research suggests that people who are more engaged with their religion are more likely to apply religious coping when facing stressful events. For these people religious coping appears to be more effective than for others. One explanation for this is that religion is incorporated into the individuals life to such a degree that it becomes his *modus operandi*

(Pargament & Brant, 1998). An example of this is found in a study amongst HIV-positive Black women in the Southern-United States, which showed that higher levels of spirituality were related to less symptoms of anxiety and depression (Braxton et al., 2007). A possible explanation for this positive effect of religious coping is that religion is an important aspect of life for Southern Black women and therefore called upon when personal crisis occurs.

1.6 Protestantism and religious coping

Now that it is clear that religious coping has a positive or a negative effect on a person dealing with personal crisis, it is time to look at how Protestant denominations use religious coping. First, it is necessary to ask the question if there even is such a thing as 'Protestant religious coping', as we are dealing with individuals with different backgrounds, experiences, beliefs and perspectives. Even if a study focusses on one specific Protestant denomination, researchers must acknowledge the diversity of people within a denomination. A person may identify as a Protestant because he is part of a church community or shares similar beliefs. However, the influence of religion on the life and the actions taken by the individual depends on the extend it is integrated into their personal identity. If religion plays a significant role in a persons life, it is more likely that religious coping occurs (Pargament, 1997).

How is it then possible to define a vague term such as Protestant religious coping? A useful way of approaching the question how to distinguish Protestant denominations is by looking at what aspects of religion are emphasized. What is emphasized in a religious tradition might indicate how a person belonging to a specific denomination is most likely to deal with a personal crisis, meaning that there could be notable differences in religious coping.

A study that deals with different Protestant denominations and religious coping was done in the United Stated. This research discovered differences in the ways that African American, Black Carribean and non-Hispanic Whites rely on God and prayer during stressful

times (Chatters et al., 2008). The data was collected by a total of 6082 interviews, consisting of 58.7% African-Americans, 26.7% Black Carribean and 14.6% non-Hispanic Whites (Chatters et al., 2008). Participants were asked about the importance of prayer during a stressful event and if they try to find strength and support from God, which are both indicators of religious coping (Chatters et al., 2008, p 376).

The results of the study showed some interesting insights into how religious coping can differ between denominations. It was found that demographic differences indicated that participants from the Southern region are more likely to use religious coping to deal with stressful events than those from the Northern region. It also revealed that Baptists reported lower levels of the importance of prayer in a stressful situation compared to other Protestant denominations such as Methodists and Pentecostals (Chatters et al., 2008). An interesting difference between Black Carribeans and African Americans was also found.

> ‘‘We found it interesting that Black Caribbeans who were Methodists were more likely than Baptists to indicate that they look to God for strength, support, and guidance, while the reverse was true among African American Methodists.’’ (Chatters et al., 2008, p 383)

This difference is examplary of why it is complicated to talk about a concept such as Protestant religious coping. It might be that there are other individual factors responsible for this statistic, besides the denominational difference. Although these studies provide some insights, there is little data available on the different religious coping strategies used by specific Protestant denominations. The research on religious coping is mostly focussed on religious traditions in general (i.e. Christianity, Catholics or Protestants). When there is more research

data available in the future, scholars should perform a comparative study on different coping styles between Protestant denominations. Although data on religious coping in specific Protestant denominations is scarce, there is enough data on this topic comparing Catholics and Protestants, which is the focus of this thesis.

1.7 Catholics and Protestants compared

Nearly all research on religious coping among Catholics is done among Roman Catholics. Although Catholicism is not divided into countless denominations as is the case with Protestantism, significant differences still exist between Catholics from different cultures. Multiple studies on religious coping among Protestants and Catholics have been conducted that offer insights about how both groups use religious coping (Alferi et al., 1999; Park et al., 1990; Tix & Frazier, 1998; Zwingmann et al., 2008).

The study of Park et al. (1990) focussed on how trait anxiety and depression were influenced by intrinsic religiousness and religious coping among Protestant and Catholic college students. The researchers hypothesized that intrinsic religiousness functions ‘‘as a life stress buffer in the prediction of trait anxiety and depression.’’(Park et al., 1990, p 563). The study yielded some interesting results. It was found that intrinsic religiousness was positively correlated to anxiety and depression for Catholic subjects (Park et al., 1990) . The opposite is true for Protestants, as the research found a negative relation between intrinsic religiousness and depression (Park et al., 1990, p 567).

It also found that Protestants who reported high levels of intrinsic religiousness experienced less depressive symptoms when facing uncontrollable negative events (Park et al., 1990). One explanation proposed by the authors is that Protestantism emphasizes faith and the internalization of the word of God in one’s life, whilst Catholicism emphasizes tradition and works (Park et al., 1990). Therefore Protestants would benefit more from intrinsic religiousness than Catholics. The research did not find evidence that supported the claim that religious coping

would act as a buffer for psychological distress during uncontrollable negative situations (Park et al., 1990). However, for controllable negative events an interesting difference between the traditions was found.

> ‘‘Religious coping served as a controllable stress buffer for Catholics, but as a controllable stress exacerbator for Protestants.’’(Park et al., 1990, p 568)

Why would religious coping increase life stress during controllable events for Protestants? It could be that when Protestants rely on religious coping during these events, they are actually distracted from better ways of coping that are more oriented towards direct problem solving (Park et al., 1990, p 568). One possible explanation for why religious coping helps Catholics deal with controllable stress is that religious coping enables them to seek forgiveness for their own actions that led to the negative event in the first place (Park et al., 1990). Or, as the authors state: ‘‘In other words, the structure of the Catholic faith might allow for the direct and active expiation of guilt associated with "self-induced" life stress.’’(Park et al., 1990, p 568). Simply put, Catholics may benefit from reducing their feelings of guilt in controllable stress situations by using religious coping strategies.

Other studies that have been conducted on religious coping among Protestants and Catholics focus primarily on stressful situations due to medical illness, which is what this thesis focuses on. A study on women going through breast cancer treatment in the US found differences in the relationship between religiosity and distress among Catholics and Protestants (Alferi et al., 1999). It found that for Catholics higher levels of religiosity resulted into experiencing higher levels of distress months after surgery, whilst the opposite was true for Protestants. This study also found that there are similarities and differences in the specific

religious coping strategies that both groups used. Because this study also focuses on the influence of religious affiliation on the use of religious coping it is useful in answering the research question of this thesis.

Another study in Germany on religious commitment and religious coping in breast cancer patients concluded that ways that Protestants and Catholics use religious coping is more similar than different (Zwingmann et al., 2008). What it also found was that Protestants used negative religious coping more compared to Catholics, and they also experienced more anxiety. This is more or less the opposite of what was found in the study on breast cancer patients in the US (Alferi et al., 1999). How come these findings differ between these studies? To answer this question this thesis will compare both studies with each other.

A study in the US among patients who received a kidney transplant examined the influence of religious coping on psychological adjustment (Tix & Frazier, 1998). This study also aimed to identify if there are any differences in the relationship between religious coping and psychological adjustment among Protestants and Catholics. Results showed that there were similarities and differences in how both groups utilize religious coping, which is why this study will also be compared with the other studies. It is now clear that there appear to be similarities and differences in how Catholics and Protestants use and benefit from religious coping. The next chapter of this thesis presents the research methodology of this thesis.

Chapter 2 Methodology

2.1 Introduction

This chapter contains the methodology used in this thesis. First I will discuss the research design which shows how I found the studies that allow me to answer the research question. Following this I shortly describe the studies that will be compared and the reason for choosing them. The relevant research definitions that will be used throughout this thesis will be presented. As the goal of this thesis is to identify the similarities and differences between how Protestants and Catholics in the West use religious coping to deal with a medical condition, I will compare three different studies on this topic. The thesis is divided into two different sections. The first section analyzes the studies apart from each other, focussing on their methods to measure religious coping, discuss their used definitions and analyze the results. The second section of this thesis is comprised of a comparison between the three studies. How do their different approaches to religious coping relate to each other? I will attempt to explain the findings by comparing the core beliefs of the religious traditions.

2.2 Research Design

As this thesis consists of a research analysis and a comparison, it will therefore review existing scientific research from within the field of psychology. To explain the differences in core beliefs I will also use sources from religious organizations and religious studies. In order to collect the relevant data the online library of Leiden University and Google Scholar were consulted the most. The scientific research for this thesis was found by using the following search terms: (religious coping) AND (Protestants OR Catholics) AND (breast cancer). Three studies for comparison have been included in this thesis. Selected articles are all peer-reviewed and cited for a sufficient amount of times, which in this case means each study has been cited over 150 times.

This research examines primarily quantitative data. The reason is because the studies to date are primarily quantitative in their approach. Based on the implications of the quantitative data this thesis aims to explain the similarities and differences of the use and efficacy of religious coping between Protestants and Catholics in the West.

2.3 Conceptual framework

To analyze the studies I searched for statistics on religious coping and its relation to other factors. I asked the following questions to distinguish between relevant and irrelevant data:

1) What scale was used to measure religious coping?
2) How does the study measure religious involvement?
3) Are there any significant relationships between religious coping and religious involvement?
4) How did the study measure distress/anxiety?
5) Is religious coping related to distress for Protestants or Catholics?
6) Are there other significant relationships between religious coping and other factors for Protestants or Catholics?
7) Can the results be explained by other relevant factors than religious coping?

Asking these questions has enabled me to look for the relevant data that deals with my research question.

2.4 Chosen studies

As mentioned in the introduction this thesis aims to answer what the similarities and differences are in the use and efficacy of religious coping among Protestants and Catholics in the West dealing with a serious medical condition. It also explains the differences by comparing the core beliefs of the religious traditions. In order to do this I will examine three different studies about religious coping and compare them with each other. Two of these studies were

conducted in the US, and one in Germany. One of studies in the US focuses on religious coping amongst Catholic and Evangelical Hispanic women who are receiving treatment for early-stage breast cancer (Alferi et al., 1999). The study in Germany concerns itself with women who were recently diagnosed with breast cancer and examines religious commitment and religious coping amongst Catholics and Lutherans (Zwingmann et al., 2008). The third study focuses on religious coping amongst Catholics and Protestants who received a kidney transplant (Tix & Frazier, 1998). The reason for analysing these three studies and comparing them is that all of them discovered similarities and differences in the ways Protestants and Catholics deal with their negative events, sometimes even contradicting each other. All three of these studies are also dealing with stressful medical induced situations, which makes them eligible for comparison.

2.5 Research definitions

This thesis focusses on religious *coping* and defines this as a process of dealing with negative life events by appealing to religious beliefs or practices (Pargament, 1997). The reason for using this definition is that scholars in the psychology of religion field are in agreement on the validity of this definition. To my knowledge there are no competing definitions of religious coping to be found. Another consideration is that the studies that I will analyse and compare all focus on religious coping and use this same definition, which is why I will use it throughout my thesis. Whenever I talk about Catholics throughout this thesis, I am talking about a group of people belonging to the religious tradition of the Roman Catholic Church. I will refer to Protestants as Christians who are members of the churches that during the reformation parted from the Roman Catholic Church. The literature review already mentioned the possible problems with such a definition. I will therefore specify which Protestant denominations were used in which study when analyzing the research.

2.6 Methodological implications and limitations

The adopted methodology allows this thesis to identify the efficacy and the use of religious coping amongst Catholics and Protestants in the West. It offers insights into how these groups deal with stressful situations and explicitly those with a medical nature. Because all three studies focus on people experiencing a serious medical condition they exist in the same category, which makes for a valid comparison. Also, the studies vary in their approaches to measure religious coping and identify it's relationship with other factors, which provides multiple perspectives on the phenomenon.

Providing explanations from the core beliefs of Protestantism and Catholicism is speculative. First, it must be noted that I will use Reformation theology to talk about the faith of Protestant, but it is not clear if there are only Reformed Protestants among the participants. Still, I believe it to be important teachings for most Protestants which is why I choose to do it this way.

Although the different approach of the studies offer a variety of perspectives on religious coping, it also complicates the process of comparison as there are different factors used. The studies measure their relevant factors at different stages in the patients process, which influences their response. Not all of these studies describe the exact individual coping mechanisms that were used by the participants, but use terms such as positive or negative religious coping. All these studies use surveys in which participants must fill in to what extend they agree with something in a scale from 0-5. People may attach different values to their feelings or perception, which can mess with the results. Finally, these studies are all cited multiple times and relevant for the research on religious coping, but the limited data on the denominational differences in the field overall complicates drawing definitive conclusions.

Chapter 3 Research Analysis

This chapter of this thesis analyzes each of the three studies on religious coping among Protestants and Catholics. The goal of this research analysis is to examine how the studies are conducted, identify the similarities and differences in religious coping between Catholics and Protestants and discuss the explanations of the authors.

3.1 Religious coping during early-stage breast cancer treatment in the US

The study of Alferi et al. (1999) aimed to discover how patients going through early-stage treatment of breast cancer utilized religious coping. In order to do this the study focused on the relationship between religiosity, religious coping and distress (Alferi et al., 1999, p 345). This study was conducted amongst 49 Hispanic women in Florida of whom 72.5% were Catholic and 23.5% were categorized as Evangelical. The Evangelical group consisted of Evangelical women, Jehovah Witnesses and one Pentecostalist and one Baptist (Alferi et al., 1999, p 346) Participants in the study were patients from the Breast Health Center in Miami-Diade between November 1993 and February 1996 and could only participate if they had no record of psychiatric illness (Alferi et al., 1999, p 345). The reason for conducting this study was to further investigate the relationship between religious coping and physical illness. Religious identitity amongst Hispanics has received little attention from the psychological field, which is another reason why this research is relevant.

Methods

Religious involvement or religiosity is the first relevant factor that was studied. This was measured by using items from the General Social Survey from Davis and Smith (1989)(Alferi et al., 1999, p 346). This survey contains items about the amount of times the woman prayed, attended church and how often she turned to her religious beliefs to deal with stress. It also asked how many times she doubted her faith and if her religious convictions

impacted her choices for undergoing treatment (Alferi et al., 1999, p 346). These questions were asked in the period before the surgery, and at 6 and 12 months after the surgery (Alferi et al., 1999, p 347).

To measure religious coping the study used items from the situational COPE (Carver et al., 1989), a list of items focusing on coping responses (Alferi et al., 1999, p 347). Participants were asked to answer four questions about religious coping, one about behavioral disengagement and one about denial (Alferi et al., 1999, p 347). To measure distress the study used a shorter variation of the Profile of Mood States (McNair et al., 1981). The main goal of this model is to indicate the moods experienced by the individual when they heard they needed surgery, and after surgery.

Results

Similarities

For both groups religious involvement was higher before surgery and fell off after 6-12 months (Alferi et al., 1999, p 348-349). An explanation for this is that the pre-surgery period is significantly more stressful compared to 6 or 12 months after surgery. This is also reported in the results on distress, which shows that stress levels were significantly lower at the 6-12 month follow-ups compared to pre-surgery (Alferi et al., 1999, p 349). There were no significant differences in the levels of distress experienced by both groups during these periods.

Both groups utilized the same two religious coping methods the most: finding comfort in religious beliefs and receiving support from fellow church members. However, taking comfort in religious beliefs was significantly more reported than the other methods (Alferi et al., 1999, p 352). Church attendance was at the same level as receiving support for both groups. (Alferi et al., 1999, p 349). Another interesting similarity is that for both groups there was a positive relationship between religious involvement and talking to a priest or pastor at post-

surgery and at the 3 months follow-up, which disappeared at the 6 and 12 months follow-up (Alferi et al., 1999, p 352). Taking comfort in religious beliefs was also positively correlated with religious involvement, but only at pre and post-surgery (Alferi et al., 1999, p 352). This suggests that especially before surgery and in the recovering period both groups use religious coping the most, which is to be expected as this period is the most stressful.

Differences

The examination of the results on religious involvement showed that at pre-surgery and after 6 and 12 months Evangelical women reported higher levels of religiosity than Catholic women. Evangelical women reported higher use of religious coping than Catholic women before surgery. After surgery it was found that Evangelical women scored higher in church attendance and reported that they received more support from other church members compared to Catholic women (Alferi et al., 1999, p 349).

The study found a positive relationship between religiosity and distress among Catholics from pre-surgery to the 12 months follow-up (Alferi et al., 1999, p 351). For Evangelical women this relationship was negative, implying that by being more involved with their religion Evangelical women lowered their distress and Catholics increased their distress during the process.

The relationship between religious coping and distress found that for Catholic women talking to a priest was related to higher levels of distress, the opposite was the case for Evangelical women who talked with a minister (Alferi et al., 1999, p 352). Overall, distress levels were lower for Protestants who used religious coping than for Catholics (Alferi et al., 1999). The following table shows the results on religious coping between both groups:

Table 4

Differences between Hispanic Catholic and Hispanic Evangelical Christians in religious coping responses, behavioral disengagement, and denial, at pre-surgery, post-surgery, 3-month follow-up, 6-month follow-up, and 12-month follow-up.

	Catholic			Evangelical		
	n	*M*	*SD*	*n*	*M*	*SD*
Getting support from the people in my church						
Pre-surgery	11	2.00	1.34	8	4.00	.00
Post-surgery	21	2.71	1.52	11	3.45	1.21
3 months	12	3.00	1.21	10	3.80	.63
6 months	13	3.23	1.17	8	3.75	.46
12 months	15	2.53	1.30	10	3.40	.84
Going to church or prayer meetings						
Pre-surgery	35	1.91	1.27	12	3.25	1.36
3 months	29	2.45	1.35	12	3.33	1.07
6 months	29	2.45	1.35	10	3.30	1.25
12 months	30	2.30	1.29	11	3.36	1.03
Talking with my priest or minister						
Pre-surgery	35	1.17	.71	12	3.00	1.48
Post-surgery	31	1.45	1.06	12	2.25	1.42
Trying to find comfort in my religion or spiritual beliefs						
Pre-surgery	37	3.76	.76	12	4.00	0.00
Post-surgery	36	3.81	.62	12	4.00	0.00
12 months	30	3.83	.69	11	4.00	0.00
Behavioral disengagement						
Post-surgery	36	1.39	.96	12	1.00	0.00
3 months	31	1.45	.77	12	1.00	0.00
6 months	30	1.37	.93	10	1.00	0.00
Denial						
Post-surgery	36	2.31	1.31	12	1.58	0.90

Note. All differences that approached significance or had effect sizes greater than .28 are displayed Response options are: 1 = I haven't been doing this at all; 2 = I've been doing this a little bit; 3 = I've been doing this a medium amount; 4 = I've been doing this a lot (Alferi et al., 1999, table 4). Adapted *from Religiosity, Religious Coping, and Distress*, by Alferi et al., 1999, p. 350. Copyright 1999 SAGE Publications London, Thousand Oaks and New Delhi.

Discussion

The results of this study illustrate that for both groups the process of dealing with their stressful situation is quite similar. The decline of religious involvement after 6 to 12 months post-surgery suggests that at the beginning of the treatment period patients call upon religion more often. A possible explanation for this is that this period is more challenging and stressful for the individual as opposed to the later stages. Both groups also report the same religious coping strategies to be most popular. The relationship between these strategies and religious involvement disappears after 3 months for both groups, which supports the idea that this is a challenging period in which religion becomes especially important for the patient.

Although the ways in which Evangelical and Catholic women use religious coping throughout their treatment process is rather similar, results suggest there are differences in the use and efficacy of religious coping for both groups. Evangelical women reported more use of religious coping strategies overall and showed higher levels of religious involvement compared to Catholics. They also reported receiving more support from church, which is not suprising considering that they reported higher church attendance. The most interesting find of this study is the relationship between religiosity and distress, which is positive for Catholics and negative for Evangelical women. This could also explain why Catholics reported lower church attendance and used religious coping less often compared to Evangelical women. A possible explanation for this difference is that Evangelical women focus more on faith and are convinced they are saved, while Catholics focus more on confessing their sins and judgement which increases distress in the face of a life threatening situation (Alferi et al., 1999, p 354).

There are limitations in this study which must be discussed. The group of participants is relatively small (n=49) and the group of Evangelical women consists of different Protestant denominations. The study therefore assumes that the different denominations share some core values that marks them as Evangelical (Alferi et al., 1999, p 354). All the participants were

women diagnosed with early-stage breast cancer with a relatively good prognosis, which means that the results do not apply to people dealing with other medical conditions (Alferi et al., 1999, p 354). What is missing from this study are items on negative religious coping which could provide insights into why these similarities and differences in the use and efficacy of religious coping between Catholic and Evangelical women were found.

3.2 Religious coping among breast cancer patients in Germany

The study of Zwingmann et al. (2008) focused on the extend to which religious commitment, religious coping and the interaction between the two can be used as a predictor of anxiety (Zwingmann et al., 2008, p 361). The main purpose of this study was to find out if a distinction between religious coping and religious commitment has any merit in predicting psychosocial adjustment (Zwingmann et al., 2008, p 363). The participants of the study were 167 german women diagnosed with breast cancer who stayed at the rehabilitation center in Germany in 2003 (Zwingmann et al., 2008, p 363). Religious background of the participants consisted of 45% Catholics, 38% Lutherans and 17% either left their church, belonged to another Christian Church or never joined a denomination (Zwingmann et al., 2008, p 363).

Methods

To measure religious commitment the Centrality Scale of Huber (2003) was used, which measures levels of religiosity. This scale is inspired by the ideas of Allport (1966) on intrinsic religiousness, which influences how people live their daily life (Zwingmann, 2008, p 363). The C-scale contains 10 items about religion such as the amount of times one prays, takes part in religious services and how important religion is to the person. It also focuses on the experience of religion by asking how frequent a person feels that God tries to communicate something to them (Huber & Huber, 2012). The variety of this scale covers most items that are relevant to

measure the religiosity of a person, but it does this in a general manner ensuring that it can be used for measuring multiple religious traditions.

For the measurement of religious coping the authors developed their own 27 item scale which is inspired by the BRIEF RCOPE from Pargament et al. (2008). These scales were comprised 18 positive religious coping items, including items about the support of their religiosity in dealing with the situation and providing meaning to it (Zwingmann et al., 2008, p 364). The rest of the items focus on negative religious coping by asking the partipant if they ever felt like their situation was a punishment by God or if they doubted their religious beliefs (Zwingmann et al., 2008, p 364). The anxiety indicator (Herrmann et al., 1995) was used to measure psychological adjustment (Zwingmann et al., 2008, p 364). In the following table the a statistical overview on the relevant measured factors is given:

Table 1

Descriptive statistics, zero-order (below diagonal; N = 141–166), and partial correlations (above diagonal; d.f. = 133–154) (Zwingmann et al., 2008, Table 1).

	M	SD	Skewness	1	2	3	4	5	6
C-scale	2.08	1.01	0.02	-	0.17*	-0.01	0.85**	0.08	-0.08
Catholic (0-1)	0.48	0.50	0.07	0.18*	-	- 0.74**	0.16	-0.05	-0.17
Protestant (0-1)	0.36	0.48	0.58**	0.01	- 0.73**	-	0.00	0.17*	0.07
PRC	1.96	1.24	-0.07	0.85**	0.16*	0.02	-	0.09	-0.15
NRC	0.89	0.81	1.02**	0.09	-0.05	0.22**	0.10	-	0.25**
HADS-D-A	1.06	0.51	1.30	-0.11	-0.16*	0.04	-0.17	0.20*	-

Note. Partial correlations adjusted for age, education and partner. See Methods section for dichotomizing (0–1) religious affiliation variables. C-scale, Centrality Scale measuring religious commitment; PRC, positive religious coping; NRC, negative religious coping; HADs-D-A, Anxiety subscale of the German version of the Hospital Anxiety and Depression Scale.

*P < 0.05, **P < 0.01. (Zwingmann et al., 2008, p 364). Table Adapted from *Religious Commitment, Religious Coping and Anxiety: a Study in German Patients with Breast Cancer*, by Zwingmann et al., 2008, p. 364. Copyright 2007 The Authors Journal compilation © 2007 Blackwell Publishing Ltd.

Results

Similarities

A relationship between religious commitment and positive religious coping was found for both groups (Zwingmann et al., 2008, p 365). It was also found that there were relationships between sociodemographic factors and religious measures. Older participants showed higher levels of religious commitment. Also, participants who enjoyed higher education or lived with a partner were less likely to use negative religious coping (Zwingmann et al., 2008, p 365). The relationship between religious commitment and religious coping in the prediction of anxiety were identical for both groups, which suggests that the differences between Protestants and Catholics in this study are minor (Zwingmann et al., 2008, p 366).

Differences

In the measurement of religious coping, Protestants reported a higher use of negative religious coping than Catholics (Zwingmann et al., 2008, p 365). Catholics reported higher levels of religious commitment, positive religious coping and less anxiety (Zwingmann et al., 2008, p 366). No further differences between the groups were found.

Discussion

The findings of this study suggest that there are more similarities between Catholics and Lutherans in Germany than differences. Although Lutherans use negative religious coping more frequently compared to Catholics, the study found that the complex relationships between

religious commitment and religious coping are the same for both groups. According to the authors, other studies (Lukatis & Lukatis 1989; Koch 1992) also concluded that Catholics and Protestants are more similar than different in Germany (Zwingmann et al., 2008, p 366). This study did find a strong relationship between positive religious coping and religious commitment which both are negatively related to anxiety (Zwingmann et al., 2008, Table 1). Also, religious commitment turned out to be a bad predictor for anxiety, whilst religious coping proved to be a strong predictor for anxiety (Zwingmann et al., 2008, p 366). This finding is is also in line with other studies and indicates that religious coping might be a better indicator than religious commitment for predicting changes in patients well being.

Clearly there are limitiations in this research that must be adressed. First, the study is a cross-sectional study, which measures all the relevant factors at one certain time. This limits the value of the data, because participants may have a different perspective on their situation throughout the process. Also, the diagnosis of the patients differed from 1-36 months (Zwingmann et al., 2008, p 363). A person who has recently been diagnosed is probably in another state of mind than someone who is already two years in their treatment process. In my opinion the use of the C scale to measure religious commitment could also be aimed more specifically at Lutherans and Catholics.

3.3 Religious coping in patients undergoing kidney transplant surgery in the US

The study of Tix & Frazier (1998) focuses on the effects of religious coping on patients who received a kidney transplant. It also examined how these effects could be influenced by religious tradition, if religious coping has a positive effect on psychological adjustment and if this relationship is different for Catholics and Protestants (Tix & Frazier, 1998, p 413). The goal of this study was to fill the gap in the research on the role of religious coping and affiliation in specific stressful situations such as undergoing kidney transplant. Previous research primarily focused on stressors which were different for all participants and lacked a longitudinal

approach (Tix & Frazier, 1998, p 412). In order to conduct this research patients from the the University of Minnesota Hospital were asked to participate and respond to a questionnaire three and twelve months post-surgery (Tix & Frazier, 1998, p 413). Questionnaires were also given to one person that provided support during the process of each patient. The total amount of participants who completed the questionnaire 3 months after surgery consisted of 239 patients and 171 partners, and 174 patients and 123 partners finished the questionnaire 12 months post-surgery (Tix & Frazier, 1998, p 413). Of these patients 36% were Catholic and 42% Protestants. The rest were either Jewish, belonging to another or no religious tradition.

Methods

Methods used at 3 months post-surgery

Religious coping was measured by a 10-item scale that examined the extend to which participants utilized religious coping to handle stress. The scale was inspired by Pargament (1990) and included items that asked the participant if they asked God for help and put their faith in his hands (Tix & Frazier, 1998, p 413). To measure cognitive restructuring a subscale of the Coping Strategies Inventory (Tobin et al., 1989) was used, consisting of items asking the participant if rethinking their situation changed their perspective on it (Tix & Frazier, 1998, p 414).

Social support was measured by the Social Provisions Scale (Cutrona & Russell, 1987) which asks the participant to what extend they feel that they can access their social network for support (Tix & Frazier, 1998, p 414). To measure to what extend the patient feels in control over his health after the transplant the internal and chance control scale from the Multidimensional Health Locus of Control Scale (Wallston et al., 1978) was used.

Methods used at 3 and 12 months post-surgery

Distress is measured by the use of the Brief Symptom Inventory (Derogatis, 1977) which asks the participant if they have experienced depressed, hostile or anxious feelings after the transplantation (Tix & Frazier, 1998, p 414). At last the life satisfaction of the participant was measured by using the Satisfaction with Life Scale (Diener et al., 1985) consisting of 5 items (Tix & Frazier, 1998, p 414). The following table shows the statistical results from the measurements of these factors:

Table 1

Descriptive Information for Patients

	Catholics			Protestants		
	M	SD	n	M	SD	N
3-month religious coping [a]	3.37	1.04	63	3.35	1.06	80
3-month cognitive restructuring [a]	3.20	0.85	78	3.10	0.81	93
3-month social support [b]	3.35	0.46	81	3.36	0.42	98
3-month internal control [c]	4.28	0.69	82	4.39	0.75	94
3-month chance control [c]	3.07	1.05	80	3.07	0.82	90
3-month distress [d]	0.59	0.45	82	0.59	0.57	96
12-month distress [d]	0.51	0.52	62	0.52	0.45	73
3-month life satisfaction [e]	4.52	1.53	82	4.52	1.47	99
12-life satisfaction [e]	4.73	1.40	60	4.76	1.39	75

Note. Different subscripts in a row indicate significant differences in means between Catholics and Protestants. a 1 = not at all; 5 - very much. b 1 = strongly disagree; 4 = strongly agree. c 1 = disagree strongly; 6 = agree strongly. d 0 = not at all; 4 = extremely. e 1 = strongly disagree; 1 = strongly agree (Tix & Frazier, 1998, Table 1). Adapted from *The Use of Religious Coping During Stressful Life Events*, by A. P. Tix & P.A. Frazier, 1998, p. 415. Copyright 1998 by the American Psychological Association, Inc.

Results

Similarities

Religious coping was a popular way to deal with the psychological distress for both Catholics and Protestants participants. The other factors such as social support, control, life

satisfaction and cognitive restructuring were almost exactly the same among both groups (Tix & Frazier, 1998, Table 1). For both groups social support was related to less distress and greater life satisfaction.

Differences

The regression analyses showed that the relationship between religious coping and levels of distress at 3 and 12 months for Protestant patients and partners were negatively related, indicating that religious coping reduced distress for Protestants (Tix & Frazier, 1998, Table 4). For Catholic patients and partners this relationship was slightly positive, increasing distress at 3 and 12 months (Tix & Frazier, 1998, Table 4). Religious coping was also significantly positively related to greater life satisfaction for Protestants, indicating that it has a positive effect on psychological adjustment, which was not the case for Catholics (Tix & Frazier, 1998, Table 4). Religious coping was associated with social support for Protestants, but not for Catholics (Tix & Frazier, 1998).

Discussion

The results of this study indicate that Catholics and Protestants both use religious coping to deal with distress in the months after receiving their kidney transplant. They also report the same levels of receiving social support, life satisfaction and cognitive restructuring. However, when examining the complex relationships between religious coping and distress the study finds that Protestants experience less distress when using religious coping to deal with their situation, whilst the opposite is true for Catholics. There was also a negative association found between religious coping and believing that health results are determined by chance for Protestants, but not for Catholics (Tix & Frazier, 1998, p 420). This indicates that Catholics experience less control when using religious coping in comparison to Protestants. This is in line with the

findings of Park et al. (1990) who found that in stressful situations which are uncontrollable in nature, Protestants experience less distress than Catholics.

One of the limitations of this study is that it makes no distinctions between specific religious coping strategies, which means that it is unclear in which way Catholics and Protestants are similar or different in using it. The study talks about Protestants but fails to define the specific denominations of the participants, which means that it is hard to use the data as a predictor for future studies.

Chapter 4 Comparison of the studies

This chapter of this thesis compares the studies analyzed in the research analysis with each other. In order to do this I will first compare the demographics of each study, discussing how these can influence the results. After this I will compare the methods used by the studies to measure religious coping. Are the studies measuring the same factors or do they take a different approach? If so, how does this impact the results of the studies? Following this a comparison of the results of the study follows. Do the studies support each other in terms of findings, or do they contradict each other? Furthermore it will discuss if their findings are in line with previous research on religious coping.

4.1 Demographics

In order to understand how the findings of the studies possibly relate to each other, it is necessary to compare the demographics of the participants. Table 1 shows the different demographics of each study, note that Tix & Frazier (1998) shows no data on stages as these do not apply to participants undergoing kidney transplantation. It also shows that for the studies on breast cancer patients all participants were women, whilst the study on kidney transplantation consists of men and women. The differences in how men and women use religious coping have received little attention in the existing research. However, a study in Denmark (Hvidtjørn et al., 2014) focused on gender differences in religousness and religious coping, and found that ‘‘men and women showed only small discrepancies in use of religious coping’’ (Hvidtjørn et al., 2014, p 1339). This is to say that gender is not relevant, but for the two studies on breast cancer participants were all women.

Nationality

Nationality is also a relevant factor in the research, as the role of religion is different within each culture. For example, the study in Germany found a strong relationship between

religious commitment and positive religious coping (r = 0.85) that was considerably stronger than studies in the United States found (Zwingmann et al., 2008, p 367). The authors explain this by stating that this is probably a result of the religious-cultural landscape of the country: belief in God is considerably lower in Germany than in the United States (Zwingmann et al., 2008, p 367).

> Concomitantly, religious beliefs are becoming increasingly personal, detached from church and heterogeneous (Frick et al. 2006). Against this background, it may be conceivable that Germans who nevertheless describe themselves as religiously committed are those who already have experienced support through religiousness and possess an easy access to positive religious coping strategies. (Zwingmann et al., 2008, p 367)

So it seems that the role of religion is intertwined with the cultural background of a country, which also influences these complex relationships between religious commitment and religious coping.

Religious tradition

In all three studies the majority of the participants are Catholics and Protestants. However, in the study on patients who received a kidney transplant the denominations are not specified. The value of this study is therefore limited, because it is unclear which denominations are included in the Protestant participants. Although this is the case, it still provides sufficient data for the purpose of this thesis as it provides insights into the use and efficacy of religious coping amongst Protestants and Catholics. The study from Alferi et al. (1999) includes an overview of the different denominations included in the Evangelical group. However, in the

actual measures on religious coping the authors have decided to combine all the represented protestant denominations in the Evangelical category. The reason for this is probably the relatively small amount of participants (n = 49). Still, this means that the results are unable to show the efficacy and use of religious coping for each denomination. In the study of Zwingmann et al. (2008) the only Protestant participants are Lutheran, which avoids these problems.

Table 1.

Demographics overview

	(Zwingmann et al., 2008)	(Alferi et al., 1999)	(Tix & Frazier, 1998)
N =	167	49	239
Gender			
Man	0	0	153
Woman	167	49	86
Age (Mean)	57	56.37	42
Nationality	Germany	United States	United States
Religious Tradition	Catholics (45%) Lutherans (38%) Other Christian Church (5%) Abandoned Church membership (10%) No Tradition (2%)	Catholics (75.51%) Jehovah's Witness (10.204%) Evangelist (8.163%) Pentecostal (2.041%) Baptist (2.041%) Non-denominational (2.041%)	Catholics (36%) Protestant (42%) Jewish (3%) Other (10%) No preference (9%)
Diagnosis	Breast Cancer	Breast Cancer	Kidney Transplant
Stage			
Stage 0	5%	10%	X
Stage l	30%	35%	X
Stagell	47%	55%	X
Stage lll	7%	0%	X
Stage lV	4%	0%	X
Non-Specified	7%	0%	X

Note. Adapted from Zwingmann et al. (2008), Alferi et al. (1999), Tix & Frazier, (1998).

4.2 Applied methods

The studies used different methods to measure important factors such as religious commitment and religious coping. It is important to understand what the advantages and limitations of these methods are, which can be achieved by comparing them.

Religious commitment

In two studies the religious involvement was measured to identify to what extend participants were actively engaging with their religion before and after their medical treatment. In Alferi et al. (2008) this was done by using a survey that focused on the frequency of religious practicessuch as prayer and church attendance, and also on the amount of times the participants religious beliefs impacted her behavior. This is a balanced way of measuring religious involvement, because it covers the practical and psychological ways of engaging with religion. However, dealing with a severe medical condition such as breast cancer may impact church attendance, which is why this item is an unreliable indicator of religious involvement on it's own. The study of Zwingmann et al.(2008) used the Centrality Scale of Huber (2003) to measure religiosity (Zwingmann et al., 2008, p 363). This 10 item scale includes frequency of prayer and attending religious services, and also measures how often one feels that God is communicating to them. This last item is interesting, because it could be said that communicating with God is more common practice among Evangelical Christians compared to Catholics.

Religious coping

All three of the studies measured religious coping in a different way. In the study of Alferi et al. (1999) religious coping was measured by using four items, which are all positive religious coping strategies. Besides religious coping they measured behavior disengagement

and denial, which are in someway related to negative religious coping strategies. However, it would be better if they added four items on negative religious coping, which would provide insights into how Catholic and Protestant women use both sides of religious coping in their process. Religious coping measured by Zwingmann et al. (2008) offers a more balanced approach, because it measures 27 items in total, including 9 items on negative religious coping. What was missing in this research is a clear overview of the actual religious coping strategies used by Catholics and Protestants. The reason for this is that the research aimed to discover the relationship between religious coping, religious commitment and psychological adjustment, instead of focusing on the individual religious coping strategies. The study of Tix & Frazier (1998) uses a 10 item scale to measure religious coping, consisting of 10 items that were focused on positive religious coping. There are no items on negative religious coping, and the research lacks results on the specific religious coping strategies used by both groups.

4.3 Comparing the results

This section discusses which similarities and differences between the use and efficacy of religious coping were found between Protestants and Catholics in the three studies.

Use of religious coping

The results on the use of religious coping from the three studies are all different from each other to a certain extend. The study from Alferi et al. (1999) is the most insightful, because it provides insights into the specific coping strategies used by each religious tradition. This research showed that Evangelical women used religious coping more than Catholic women. Catholic women visit church less often and receive less support of fellow church members at pre-surgery and at the 3,6 and 12 month followup (Alferi et al., 1999, Table 4). They also report higher levels of behavioral disengagement and denial post-surgery (Alferi et al., 1999, Table 4). Although these differences in the use of religious coping were measured, there is one coping

item which is almost identical for both groups. Trying to find comfort in my religion or spiritual beliefs showed almost the same levels for both groups (Alferi et al., 1999, Table 4). It is important to note that the religious coping items of this study are all forms of positive religious coping.Comparing these results to the results of Zwingmann et al. (2008), which also focuses on patients with breast cancer shows a different picture. Although there are no results on the specific religious coping strategies used, it shows differences between the use of positive and negative religious coping.

This study did not discover a relationship between Protestants and positive religious coping, but it did find a significant positive partial correlation between Protestants and negative religious coping (Zwingmann et al., 2008, Table 1). There was no correlation found between Catholics and negative religious coping in this study, which suggests that Protestants made more use of negative religious coping strategies. This is different from the findings of Alferi et al. (1999), which indicated that Protestants used positive religious coping strategies more than Catholics. It is hard to explain this difference because it is unclear which exact religious coping strategies were measured in the German study, and negative religious coping is not measured in the US study. A possible explanation is that the cultural differences between Germany and the US influences the position of religion in society, which affects the importance of certain beliefs for religious individuals. Another relevant factor is that the Evangelical participants in the US study are Hispanic and the participants in Germany are most likely caucasian lutherans. In the US Hispanics reports show that religion is overall more important for Hispanics than for non-Hispanics (Westoff & Marshall, 2010). This could influence the use of positive religious coping, but this explanation is not sufficient to account for the differences.

The study of Tix & Frazier (1998) involves participants with a different diagnosis than the other two studies, which is important to remember during the comparison. Protestants and Catholics reported almost identical levels of religious coping use. This is different from the

other two studies that found differences between the use of positive and negative religious coping between the groups. A logical explanation for this would be that the diagnosis of these participants determined their use of religious coping.

Efficacy of religious coping

Comparing the results of the three studies reveal interesting similarities and differences in the efficacy of religious coping. In order to identify the efficacy of religious coping its relationship with distress must be discussed. The US study of Alferi et al. (1999) showed that religious coping was related to less distress for Protestants and more distress for Catholics if all coping items are taken into consideration. This differs from the findings of Zwingmann et al. (2008) that found that Catholics reported a little bit lower levels of anxiety than Protestants, which makes sense considering that ‘‘Anxiety was negatively tied to positive religious coping and positively to negative religious coping’’ (Zwingmann et al., 2008, p 365). The findings of Tix & Frazier (1998) found a negative relation between religious coping and distress for Protestants and the opposite for Catholics, which resembles the findings of Alferi et al. (1999).

It is difficult to determine the reason for the difference in results between the German study and the US studies, because two studies show no results on the actual religious coping strategies used. This is partially due to the aim of the studies, but is also a result of the relatively small differences found between the use of religious coping among Catholics and Protestants. According to the authors, a possible explanation for why there were almost no differences found between the groups was because in Germany Catholics and Protestants are very similar (Zwingmann et al., 2008, p 366).

4.4 Accounting for the differences

This section discusses how the differences in core beliefs possibly influences the use and efficacy of religious coping of Protestants and Catholics.

Sola fide versus Faith and works

The differences in the core beliefs of Catholics and Protestants are for a large part determined by the emergence of Reformed theology. Originally this theology came into existence when Martin Luther wrote his theses which consisted of a critique of the Catholic church, and his own beliefs (Bagchi & Steinmetz, 2004). This led to the emergence of the five solas which form the core of the Reformed theology. One of these core beliefs of this theology is *sola fide*, also known as justicifation by faith alone (Bagchi & Steinmetz, 2004, p 183). This belief states that in order to be saved by God one must simply have faith in Jesus, as opposed to the idea of the Catholic church that requires faith and works for salvation. How can this difference possibly influence the ways in which both groups use religious coping? It is important to understand that a life threatening situation such as breast cancer influences the individual in several different ways.

From the moment a woman receives this diagnosis she is facing a medical condition which may take her life. Therefore the question about whether one is saved or not suddenly becomes really important. If this woman is a Reformed Protestant and thinks about her salvation, it is likely that she only thinks about how strong her faith has been over the course of her life, since that is the main requirement to receive salvation. For a Catholic woman experiencing the same situation, there is a good chance that she starts reflecting on the works she has done. It is possible that the emphasis on works can cause stress for the woman, because how can she be certain that she did enough?

Church authority versus priesthood of all believers

Another difference that could impact how religious coping is used is found in the authority of the institution for Catholics and the personal authority for Reformed Protestants.

In order to reach salvation Catholics must follow the teachings of the Catholic Church. One requirement is that individuals must accept the sacraments.

> The Church affirms that for believers the sacraments of the 2003 New Covenant are necessary for salvation.51 "Sacramental grace" is the grace of the Holy Spirit, given by Christ and proper to each sacrament. The Spirit heals and transforms those who receive him by conforming 460 them to the Son of God. (CCC, 2000, 1129)

The Catholic Church received these sacraments from Christ , which means that Catholics receive salvation through the authority of the Catholic Church. However, the sacraments alone are insufficient to receive salvation. Members of the Catholic Church must also live a righteous life and do penance. What is different between the teachings of the Catholic Church and Reformed Protestantism is that the latter focuses more on the authority of the person itself. Justification by faith alone is one example of this, but there are also other beliefs that illustrate this. For Protestants there is also the belief of *sola scriptura*, the belief that what is written in the Bible is the ultimate authority of how a Christian should live one's life (Bagchi & Steinmetz, 2004). Reformed Protestants differ from Catholics because they view the Bible instead of the church as the authority over one's life. This belief also contributed to the concept of the priesthood of all believers.

> ''Luther said that all Christians are called to minister, and he exhorted church members to contribute in ministry to people, both inside and outside the church.'' (Thorsen, 2020, p 164)

This is completely different from Catholics who can only reach salvation through the authority of the church. Catholics have to go to church to be baptized, Reformed Protestants can be baptized by any true believer of the Protestant faith.

What this shows is that Catholics are more dependent on the church and its teachings compared to Reformed Protestants. In a situation that is life threatening these beliefs could affect the response of the individual towards it. Maybe Catholics experience more distress during these situations because they are experiencing an uncontrollable stressor, which means confessing is not effective as they are not responsible for the situation in the first place. A somewhat similar explanation is provided by Park et al. (1990) who found that Catholics experience more distress than Protestants when faced with uncontrollable stressors. Protestants may experience less distress because they believe they are already saved, which alleviates concerns about potentially dying.

4.5 Collectivism and individualism

The differences in beliefs also impact the importance of the church community for both groups. What it means to be religious for Catholics is inevitably tied to the community of the Catholic Church, because one can only receive salvation by engaging with the institution. For Protestants salvation is much more of a personal matter due to the emphasis on faith and scripture alone. Does this mean that Protestantism is related to individualism and Catholicism to collectivism?

According to the study of Cohen & Hill (2007) this is probably the case. They conducted a study among Protestants, Catholics and Jews in the US in order to find out if these groups show more collectivistic or individualistic characteristic (Cohen & Hill, 2007). This was done

by measuring the extrinsic and intrinsic religiousness of the participants (Cohen & Hill, 2007). The following results were found:

> ‘‘For Protestants, the individualistic aspects of religious identity that are contained in the intrinsic religiosity scale seem to resonate more than they did with either Catholics or Jews, as reflected in the higher mean scores for Protestants.’’ (Cohen & Hill, 2007, p 726)

It also found that ‘‘the items in the community-oriented extrinsic religiosity scale were endorsed more by Catholics and Jews than by Protestants’’ (Cohen & Hill, 2007, p 726) which showed that Jews and Catholics were overall more collectivist compared to Protestants (Cohen & Hill, 2007).

This notion of Catholics being more collectivistic and Protestants showing more individualistic characteristics could influence the use and efficacy of religious coping in certain ways. It could be that Catholics facing a serious medical condition could be more inclined to visit church and have a conversation with a priest, whilst Protestants could be more inclined to focus on their personal relationship with God. Unfortunately, the results of the comparison in this thesis offer no support for this suggestion. Alferi et al. (1999) showed that church attendance was higher among Evangelical women before and after surgery. Catholics also received less social support from other church members, which rejects the possible explanation. Social support was the same for both groups in Tix & Frazier (1998) and the study of Zwingmann et al. (2008) did not measure these factors.

4.6 Socioeconomic factors

Besides explaining the similarities and differences by looking at the core beliefs of the religious traditions, it is also necessary to look at other factors that could be responsible for differences in religious coping. Zwingmann et al. (2008) found that older participants were more likely to use negative religious coping. People with a higher level of education and those with a partner showed lower use of negative religious coping (Zwingmann et al., 2008, p 365). The participants in the study of Alferi et al. (1999) were all Hispanic women with a ‘‘low socio-economic status’’(Alferi et al., 1999, p 346). In the study of Tix & Frazier (1998) the demographics showed to influence religious coping. All these results suggest that socio-economic factors such as age, income and education do have an impact on religious coping. Future research should try to identify the impact of these factors on the use and efficacy of religious coping.

4.7 Implications for Religious Studies

What do these findings on the use and efficacy of religious coping amongst Catholics and Protestants mean for religious studies? The field of religious studies focuses on the role of religion in the world, which includes studying religious practices, beliefs and organizations. What these results show is that the way in which people use their religion to deal with serious medical conditions may be slightly different between cultures. Understanding the role and impact of religion from a cross-cultural point of view is the task of religious studies scholars. These results illustrate why religious studies is important as they indicate that Catholics and Protestants in different cultures use religious coping in other ways. For that reason it is necessary to study the relationship between culture and religion.

What it also shows is that there appear to be certain patterns in the use of religious coping among Protestants and Catholics. An example of this is that in Alferi et al. (1999) all

patients reported nearly the same use of trying to find comfort in religion (Alferi et al.,1999, p 350). What this shows is that in these stress-inducing situations religion plays a vital role in the life of Christians, regardless of the tradition. Religious studies scholars could help investigate why these patterns of religion exist and if there are elements to religion in general that are similar for all religious traditions.

4.8 Conclusion

It is now clear that there are similarities and differences in how Protestants and Catholics use religious coping to deal with a serious medical condition. The first thing to notice is that the studies indicate that the use of religious coping is not that different between both religious traditions. The results of the study of Alferi et al. (1999) illustrate this in the clearest way, because it reveals the actual religious coping strategies used by both groups. It shows that when Protestants and Catholics are faced with a serious medical condition they try to find comfort in their religion. This shows that the internal relationship with religion is an important factor for people dealing with a medical condition. Compared to the other religious coping strategies this one is clearly the most popular for both groups. That there are more similarities than differences in the use of religious coping between the groups is also supported by the study of Tix & Frazier (1998). The only problem with this study is that it is unclear what strategies were used by the participants. It is difficult to explain why the study of Zwingmann et al. (2008) showed that protestants used more negative religious coping than Catholics. Cultural differences between the US and Germany could be a possible explanation for this.

The results show that there is a difference between the efficacy of religious coping among Protestants and Catholics. The studies in the US both show that religious coping is negatively related to distress for Protestants. However, the study in Germany shows that Protestants experience slightly more anxiety and report a higher use of negative religious coping. The explanation for this most likely has to do with the cultural differences between the

two countries. More research should be conducted to figure out the impact of cultural differences on religion and religious coping.

It is possible that the differences in core beliefs between Protestants and Catholics can account for the differences in use and efficacy of religious coping. Because the patients are facing a threat to their life, salvation becomes a very important topic to them. For Catholics there are multiple requirements in order to be saved, whilst Protestants are saved by faith alone. This may be the reason why the US studies showed that Catholics experience more distress than Protestants during these challenging times. The findings by Park et al. (1990) on the difference between controllable and uncontrollable stressors also offers an interesting explanation. The studies that were compared in this thesis all involved uncontrollable stressors, which would suggest that high levels of intrinsic religiosity would reduce distress in Protestants. Although intrinsic and extrinsic religiosity was not measured in the studies, it is possible that the Protestants dealt better with distress due to their intrinsic religiosity. Still, this is only speculation and requires more research to be confirmed. This is also the case with the distinction between Catholics being more collectivistic and Protestants being individualistic: the results of the studies investigated in this thesis do not support this idea, but future studies might.

Socio-economic factors influence the use of religious coping among patients. It is important that researchers examine the relationship between these factors and religious coping, because this reveals under what conditions someone is more likely to use one religious coping strategy over the other. It is possible that socio-economic factors influence the use and efficacy on religious coping more than religious affiliation. This should be investigated in future research.

The findings of these studies show why religious studies is important. Belonging to a religious tradition influences the behavior of a person during times of struggle, and this differs between cultures. There are patterns of religious coping that show religion to be extremely

important during these stressful situations, which appears to be mostly the same for Catholics and Protestants.

It is important to consider that the results of this thesis are based on three studies with a total of 455 participants. The implications of these results are therefore limited, but can still be used to identify what future research should consider. The first thing is to simplify the data collection on religious coping between different religious traditions. In order to categorize the data on religious coping in a practical way, future research on religious coping should try to develop measurement scales that are designed for specific religious traditions. This would make the process of comparing these studies more efficient and makes the topic more accessible for other fields of study. The other thing that should be studied is the relationship between religious coping and distress in situations that involve controllable stressors. This could provide more data on the suggestion that Catholics are more comfortable dealing with controllable stressful situations than Protestants. What is also important to consider is that the process of going through a medical illness can be very volatile in terms of mood changes. For this reason it is better to perform longitudinal studies that include multiple moments of measurement.

This thesis has found that religious coping can be a useful tool to help patients during their process of recovering from a medical condition. Negative religious coping can make the process harder by increasing distress or anxiety levels. The use of religious coping is mostly the same between Catholics and Protestants. However, there are differences in the efficacy of religious coping. Two studies from the US suggest that religious coping benefits Protestants in their process, as it reduces levels of distress. The German study found that Protestants used more negative religious coping and reported higher anxiety levels. In order to discover the origin of these differences more research must be done on religious coping among Catholics and Protestants.

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