The Relationship between Religious Orientation and Coping Styles among Older Adults and Young Adults

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Abstract

Religion and spirituality play an especially important role in the lives of older adults and may have a positive impact on their mental health. Despite historically tense relationships between religion and psychology, there has been an increase in research concerning the intersection of these topics. Specifically, the relationship between religion and coping has been a major theme. Previous research has indicated that differing religious orientations (i.e., intrinsic versus extrinsic) can influence coping style. Other research has shown differences in coping among older versus younger adults. Research investigating impact of religious orientation and coping among older versus younger adults, however, remains sparse. This is especially important given the developmental changes that occur in adulthood with regards to coping. In order to evaluate relationships between religious orientation and coping among older versus younger adults, we compared two age cohorts and found differential patterns of correlations. Seemingly contradictory results for how one's religious orientation may influence coping styles emerged. The theory of acceptance and commitment therapy and anunderstandingof differences between specific stressors and life events, however,may explain these differences. These results have implications for working with older adults.

Keywords: religious orientation; coping; older adults; Jewish

1. Introduction

Religion is an important part of the lives of many people, especially older adults (Lauder, Mummery, & Sharkey, 2006), and can serve as a type of coping mechanism for them. In addition, religious involvement appears to play a moderating role with regards to quality of life among older adults with depression and anxiety (Huang, Hsu, & Chen, 2011). Also, a large percentage of older adults prefer to have religion and/or spirituality incorporated into their therapy addressing depression and anxiety (Stanley et al., 2011). As such, it's important for mental health therapists to have an understanding and appreciation of the role of religion when working with their clients. Pargament (1997), however, explained that the relationship between psychology and religious communities has been tense. There has been a long history of antagonism between the mental health profession and religious vocations (Boehnlein, 2006). One of the reasons for this is that the mental health profession and religions provide different (sometimes widely different) explanations for life's challenges (Curlin et al., 2007).

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The rift between psychology and religion historically increased as a result of attacks from both sides. In fact, some priests have criticized psychoanalysis as materialistic and discouraged Catholics from receiving and providing such treatment. Conversely, Freud directly antagonized religious authorities by equating religion with neurotic conditions and even went so far as to call religion "the enemy." Also, none of the four primary theoretical models of psychology has befriended religion as important (Nelson, 2009). In addition, there have been assertions that there is a negative relationship between having religious beliefs and success in the sciences, thereby increasing the rift between psychology and religionand forcing some psychology professionals to abandon religious practices.

Nelson (2009) indicated that there are several barriers that make studying psychology and religion together difficult. One of these barriers is that few people have expertise in both psychology and religion. A second barrier is that philosophical and religious writings used to explain this relationship are often difficult to understand. Finally, a third barrier is that although the diversity of people who study this area creates multiple perspectives, these multiple perspectives also create confusion and difficulty understanding and mastering the material in sufficient detail to be able to conceptualize it and create meaningful research. MacKinlay and Dundon (2012) noted that studying religion is difficult because religion is too broad and difficult to objectify, making analysis of results difficult.

Given the historicallycontentious relationship between psychology and religion, it is not surprising that mental health therapists used to eschew the idea of addressing religious and spiritual issues during therapy sessions. Recent research, however, has shown this previous prohibition to be waning (Post & Wade, 2009). Delaney, Miller, and Bisono (2007), for example, found the majority of 258 members surveyed from the American Psychological Association reported that religion is beneficial in therapy. Furthermore, clients also have expressed that religion and spirituality are important to incorporate into counseling. Post and Wade (2009) showed that 63% of clients reportedthey felt it was appropriate to discuss religious concerns in therapy and 55% wished to do so. Boehnlein (2006) noted several reasons why it has become increasingly important and acceptable to incorporate religion into psychotherapeutic processes, including that some recently developed theoretical practice approaches have their basis in traditional religious/spiritual observances and increased interest among mental health professionals in the value of religion and spirituality.

In addition to increasing acceptance of religion and spirituality by psychologists and other mental health professionals, religious institutions are increasingly acknowledging the role of mental health in healing, coping, and overall wellbeing. In fact, Boehnlein (2006) explained that many religious organizations have funded mental health organizations. This has increased the importance of clinicians becoming familiar with religious principles and practices and of researchers examining outcomes of combined therapeutic approaches. To investigate effectiveness of incorporating religion and spirituality into psychotherapy, Smith, Bartz, and Richards (2007)utilized a meta-analytic process to review previous studies. They found that this combination of interventions providedan effective form of therapy.One reason for this may be that many people turn to religion as a form of psychologically coping with stress.

Largely because of improved relations between religious and mental health professionals, there has been a huge influx of religious research pertaining to the importance of mental health and coping (Gall, Charbonneau, Clarke, Grant, Joseph & Shouldice, 2005; Koenig, 2006). Recent research has shown the importance of religion as a coping mechanism/strategy for a variety of different concerns, including eating behaviors(Pirutinsky, Rosmarin, & Holt, 2012), alcohol use among college females (Stoltzfus, & Farkas, 2012), breast cancer (Thune-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2011), and prevention of illness and reduction in mental health symptoms (Haber, Jacob & Spangler, 2007).

Incorporating religion into therapy can help individuals create meaning from loss and aid in the process of coping with stressful events (Boehnlein, 2006; Denney, Aten, &Leavell, 2011;Moussa, & Bates, 2011).Interestingly, some recent research has indicated that stressful life events may affect coping differentially among adults during different phases of adulthood and that coping style may change as individuals age (Brennan, Holland, Schutte, &Moos, 2012; Gooding, Hurst, Johnson,Tarrier, 2012; Hur, MacGregor, Cherkas, Williams, & Spector, 2012).Specifically, problem-focused coping appears to increase with age while emotion-focused coping remains unchanged (Trouillet, Doan-Van-Hay, Launay, & Martin, 2011). Consistent with this finding is that older adults also tend to report lower levels of dysfunctional coping than do younger adults (Stevenson, Brodaty, Boyce, & Byth, 2012). Coping processes also differ based on whether one has an intrinsic or extrinsic religious orientation (Ysseldyk, Matheson, & Anisman, 2011). Extrinsically religious people tend to be ambivalent andengage minimally in religious practices for the sake of religion itself (Roesch & Ano, 2003). People who have an extrinsic religious orientation tend to exhibit a utilitarian approach by using religion for instrumental means (Haber et. al., 2007). Intrinsically religious people, in contrast, hold religion as the primary purpose of one's life.

Pargament (1997) explained that studying religion and coping together can help increase our understanding of how one copes and improve our understanding of religion and religious practices. Studying religion and coping together can also help clarify the ways in which individuals use specific coping skills that can be both detrimental and beneficial in the coping process (Pargament, 1997). Also, a recent study (Horning, Davis, Stirrat, & Cornwell, 2011) revealed use of differential coping strategies among religious versus non-religious older adults. In addition, how one defines their specific religion can impact coping strategies which, fueled by the beliefs of the person, have a direct effect on that person's adjustment to change (Roesch & Ano, 2003), and these effects may vary based on one's age.Although research has increased in this area, researchers are now trying to understand the relationship between religion and coping styles, differences between cohorts, and possible developmental changes. Understanding how these variables interact can help both religious leaders and mental health professionals identify effective means of supporting individuals who come to them for assistance. The purpose of this present research study, therefore,was to examine the relationship between religious orientation and coping styles in older adults and college students. We completed this study in conjunction with another study; therefore, we present only the instrumentation and findings from this study in this paper.

2. Method

2.1 Participants

In order to complete this study, we utilized two different age cohorts. The first cohort consisted of 41 undergraduate female students from a small liberal arts university in Pittsburgh, Pennsylvaniaand recruited from first year non-psychology based classes and ranged in age from 18-23. The second cohortoriginally consisted of 20 participants recruited from two local Jewishfaith-based assisted living facilities, but two participants had incomplete data, so we eliminated them from analysis. Thus, the assisted living cohort consisted of 18 older adults, 4 male and 14 female residents who ranged in age from 65-95 years. These residents were all competent to participate in the study, and no participants had a guardian. Demographic information regarding both samples of participants appears in Table 1.

Table 1: Demographic Information of the Entire Sample

Age					**N**		**Percent**
18-19					27		45.8%
20-29					14		23.7%
60-69					1		1.7%
80-89					10		16.9%
90-100					7		11.9%
Gender					**N**		**Percent**
Male					4		6.7 %
Female					55		93.2%
Connected to specific religion					**N**		**Percent**
Yes					44		80%
No					15		25.4%
Type of Religion							
Type	**N**	**Type**	**N**	**Type**	**N**	**Type**	**N**
Roman Catholic	8	Agnostic	1	Presbyterian	3	Christian	5
Heathen	1	Protestant	1	Episcopalian	2	Jewish	18
Practicing religion					**N**		**Percent**
Yes					**29**		55.8%
No					**23**		44.2%
Do you consider yourself spiritual					**N**		**Percent**
Yes					37		50%
No					21		36.2%

2.2 Instruments

2.2.1 Demographic Questionnaire

We used a demographic questionnaire to collect information on age and gender of participants. Due to the religious nature of our study, we asked participants if they felt connected to a specific religion, if they were practicing this religion and, if so, what religion.

2.2.2 Cope

The COPE is aself-report multi-dimensional instrument that assesses an individual's reaction to stress. This measure consists of 15scales that measure distinctively different types of coping. These scales include problem-focused coping scales (active coping, planning, suppression of competing activities, restraint coping, seeking of instrumental social support), emotion-focused coping scales(seeking of emotional social support, positive reinterpretation and growth, acceptance, denial, turning to religion), and fivescales measuring other forms of coping (focus on and venting of emotions, behavioral disengagement, mental disengagement, humor, and drug/alcohol use). Each of these scales contain four questions pertaining to the specific measure (Carver, Scheier, &Weintraub,1989). For a description of each subscale, refer to Carver, Scheier, and Weintraub (1989).

2.2.3 Religious Orientation Scale (Allport & Ross, 1967)

The Religious Orientation Scale is a 21-item scale that assesses specific religious behavior categorized into an intrinsic behavior subscale and extrinsic behaviorsubscale. These two subscales look at religion as a motivational construct. The extrinsic subscale assesses the extent to which individuals use religion as an instrument to reach self-set goals of comfort and sociability.

The intrinsic subscale assesses the extent to which individuals use religion as a pathway towards reaching goals set by the religion (Burris, 1999). Both subscales have high internal consistency(intrinsic scale, αequals .85 and extrinsic scale, α equals between .70 and .75; Haber et al., 2007).

2.3 Procedure

In order to collect data, the principal investigator obtained permission from two professors to enter into their classes to distribute surveys. The investigator briefly described the procedure of the study as well as purpose of the study to students. Students had the option whether or not to participate. After agreeing to participate in the study, students signed a consent form and received a packet containing the demographic questionnaire, The COPE, and The Religious Orientation Scale. After finishing surveys, students received a list of chaplains to call if they felt the desireto do so.

In order to collect data for the older adult population, the principal investigator worked with the activities director at one facility and a Licensed Clinical Social Worker at the other facility. With the activities director, the principal investigator organized an activity forwhich there was a brief description of the study with a sign up list. The principal investigator also gave each resident a flyer to inform them of the study. Participants either attended the activity or met individually with the principal investigator. In both scenarios, the principal investigator explained the study and conditions for participating. The principal investigator then administered the survey. Those with visual or hearing impairments completed the surveys orally. At the other assisted living, the LCSW gave the principal investigator a list of residents who would be able to participate. The principal investigator called those residentswho agreed to participate and met with them individually to complete surveys. Those with visual or hearing impairments completed surveys orally.After finishing surveys,the older adultsreceived a list of chaplains to call if they felt the desireto do so.

3. Results

We used correlational analyses in order to evaluate relationships between the 15 subscales on the COPE and the intrinsic and extrinsic religious orientation subscales. Because our interest was in evaluating differential responding between the two different age cohorts, we computed correlations separately for older adults and younger adults. There were no statistically significant correlations between extrinsic religious orientation and any of the COPE scales for younger adults. There were statistically significant relationships between intrinsic religious orientation and religion, restraint coping, and planning among the younger adult cohort. In contrast, for older adults, extrinsic religious orientation correlated significantly with several COPE scales, including mental disengagement, focus on and venting of emotions, active coping, behavioral disengagement, restraint coping, and seeking emotional social support. Also for the older adults, there were several statistically significant correlations between intrinsic religious orientation and COPE scales, including positive reinterpretation and growth, focus on and venting of emotions, religion, and suppression of competing activities. All of the statistically significant correlations were positive correlations (see Tables 2 and 3).

Table 2: Correlations between the 15 Cope Scales and 2 Religious Orientations Scales for Younger Adults

Cope Scales	Religious Orientation			
	Intrinsic		Extrinsic	
	Correlation	Significance	Correlation	Significance
Positive Reinterpretation and Growth	.206	.203	.196	.233
Mental Disengagement	.109	.503	-.182	.268
Focus on and venting of emotions	.140	.389	-.063	.701
Seeking Instrumental Social Support	.223	.166	.023	.888
Active Coping	.239	.137	-.037	.825
Denial	-.208	.198	.013	.938
Religion	.727	.000	.258	.113
Humor	.161	.320	.079	.633
Behavioral Disengagement	-.103	.528	.107	.517
Restraint Coping	.476	.002	.303	.060
Seeking emotional social support	.094	.563	-.008	.962
Substance Use	-.149	.357	-.198	.227
Acceptance	.112	.492	.171	.299
Suppression of Competing activities	.165	.308	.153	.353
Planning	.340	.032	.037	.825

Table 3: Correlations between the 15 Cope Scales and 2 Religious Orientations Scales for Older Adults

Cope Scales	Religious Orientation			
	Intrinsic		Extrinsic	
	Correlation	Significance	Correlation	Significance
Positive Reinterpretation and Growth	.494	.044	.305	.251
Mental Disengagement	.416	.097	.687	.003
Focus on and venting of emotions	.484	.049	.512	.043
Seeking Instrumental Social Support	.308	.228	.325	.220
Active Coping	.251	.331	.558	.025
Denial	.007	.980	.126	.642
Religion	.759	.000	.202	.452
Humor	-.107	.684	.281	.291
Behavioral Disengagement	-.076	.772	.558	.025
Restraint Coping	-.138	.597	.506	.045
Seeking emotional social support	.360	.155	.523	.037
Substance Use	*	*	*	*
Acceptance	.118	.653	.211	.434
Suppression of Competing activities	.543	.024	.381	.145
Planning	.281	.275	.142	.601

* There was no variance at all in this variable. Hence, we were unable to compute these statistics.

We also completed a multivariate analysis of variance (MANOVA) test in order to comparemean scores of the two different cohorts included in the survey on all of the variables. Age group served as the independent variable while the 15 subscales on the COPEalong with intrinsic and extrinsic religiosity subscales from the Religious Orientation Scale were our dependent variables.

Results from the MANOVA revealed a statistically significant result for group (i.e., older versus younger adults), multivariate F (17, 36) = 2.90, p = .004. Given the statistically significant MANOVA, we computed univariate ANOVAs for each of the dependent variables. These ANOVAs revealed statistically significant differences between the two age cohorts on extrinsic religious orientation, mental disengagement, seeking instrumental social support, and suppression of competing activities. Older adults were significantly more extrinsically religious and used suppression of competing activities more than younger adults. Younger adults, on the other hand, used mental disengagement and seeking instrumental social support more than older adults (see Table 4).

Table 4: Univariate ANOVAs Comparing Older versus Younger Adults on Cope and Religious Orientation Scales

	Young Adults Mean ±S.D.	Older Adults Mean ±S.D.	F	p
Positive Reinterpretation and Growth	12.62 ±2.67	12.33 ±3.62	0.10	.755
Mental Disengagement	11.13 ±2.49	9.13 ±3.48	5.52	.023
Focus on and venting of emotions	10.69 ±2.97	9.27±3.71	2.17	.147
Seeking Instrumental Social Support	12.08 ± 2.75	10.00± 3.30	5.54	.022
Active Coping	11.54 ±2.30	12.33 ± 2.79	1.14	.290
Denial	5.74 ±2.26	6.13 ± 2.88	0.28	.601
Religion	9.46 ± 4.90	10.00±4.41	0.14	.712
Humor	10.41 ± 3.45	8.33 ±4.61	3.24	.078
Behavioral Disengagement	6.64 ± 2.03	7.73±3.03	2.35	.131
Restraint Coping	9.72 ± 2.16	10.73±3.15	1.83	.182
Seeking emotional social support	12.31 ± 3.25	10.53 ±3.56	3.06	.086
Substance Use	5.03 ± 2.06	4.00 ±0.00	3.68	.061
Acceptance	11.59± 2.74	12.27 ±3.75	0.54	.468
Suppression of Competing activities	8.74 ± 2.07	10.33 ±2.89	5.07	.029
Planning	12.08 ± 2.68	12.73±3.95	0.49	.485
Extrinsic religious orientation	28.44± 8.49	34.67 ±10.08	5.26	.026
Intrinsic Religions orientation	21.49± 9.30	24.53 ±8.25	1.23	.272

4. Discussion

The current study found an interesting differential response pattern between older and younger adults when comparing extrinsic and intrinsic religious orientation with coping styles. Our findings suggest a correlation pattern among older adults that initially appears inconsistent. On the one hand, those who have a high extrinsic religious orientation have a tendency to actively cope and seek emotional social support; on the other hand, they also mentally and behaviorally disengage. These two patterns of coping appear contradictory; one style is active and the other is passive, but both correlate highly with extrinsic orientation. Perhaps older adults, with their life experiences, have developed a sense of whether or not they can effect change in a situation. If they can, they actively address it; if not, they disengage and passively accept it.Interestingly, this pattern of coping is consistent with a prayer (often referred to as the Serenity Prayer) written by Reinhold Niebuhr (1986), a professor at Union Theological Seminary in New York City. This prayer asks for acceptance for the things that a person cannot change and courage to change the things they can.Research doessupport that previous life experiences and other intervening factors can impact implementation of differential coping strategies (Towsley, Beck, & Watkins, 2007). Future research will need to devise ways to investigate if this possible explanation is indeed true.

Our study also shows that older adults were more likely to suppress competing activities than were younger adults. This is consistent with previous research suggesting that as people age they may feel less able to cope with their lives (Lowis et. al., 2011). Older adults are more likely than younger adults to experience stressors that take additional energy to solve, such as health problems, so they may need to suppress competing activities in order to utilize available energy to deal with those problems. In addition, younger adults tend to consider their stressors more changeable than do older adults (Folkman et. al., 1987), but older adults, through normal developmental processes, may have learned to adopt effective coping mechanisms, one of which is to discriminate situational factors that warrant differential types of coping and another of which is to utilize intrapersonal sources of social support. Although these findings are relatively strong, our study included relatively homogenous groups. Therefore, it is not possible to generalize these results to other populations. These results do, however, provide some ideas for future research with additional populations.

Despite the limitations generalizing our results to the population as a whole, our results do provide some theoretical and empirical support for understanding the basis of a relatively new therapycalled Acceptance and Commitment Therapy, a religiously sensitive therapy that focuses first on helping explore a person's spiritual and religious values as well as other values. Therapy then addresses any experiences over which the client had no control, especially in relation to their values. Finally, patients make a commitment to act in concert with their values. Research has begun to investigate impact of this therapy. A recent publication (Bergemann, Siegel, Belzer, Siegel, &Feuille, 2013) described mindfulness-based therapies, including acceptance and commitment therapy, and how mindfulness may assist in developing a deep spiritual connection, and Karekla and Constantinou (2010) presented a case example using Acceptance and Commitment Therapy with a patient who had cancer as a means of describing how to use the therapy to help address religious coping among patients with cancer.

It seems reasonable to utilize the same approach with other diseases and conditions as well. In fact, acceptance-based therapies have begun to receive a substantial amount of support for coping with a variety of different issues and problems, including smoking cessation (Litvin, Kovacs, Hayes, & Brandon, 2012), panic disorder (Meuret, Twohig, Rosenfield, Hayes, & Craske, 2012), chronic pain (Bhatnagar, 2011; Branstetter-Rost, Cushing, & Douleh, 2009;Thorsell, Finnes, Dahl, Lundgren, Gybrant, Gordh, & Buhrman, 2011), diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007) and even alcohol abuse (Vieten, Astin, Buscemi, & Galloway, 2010).Although authors have described the results of their studies as preliminary, the wide array of problems addressed and strength of effect evidenced has begun to provide a wellspring of support for these therapies.Interestingly, especially in light of the findings of the current study, recent studies have begun to look at use of Acceptance and Commitment Therapy for older adults, with positive results for both pain (McCracken & Jones, 2012) and anxiety (Wetherell et al., 2011).

Results from the current study may have significant implications for practitioners engaged in Acceptance and Commitment Therapy. For instance, future studies need to examine if there is any differential treatment impact of Acceptance and Commitment Therapy on older versus younger adults. Future studies could also examine if there is any differential response to treatment based on an individual's religious orientation (i.e., intrinsic versus extrinsic) entering into therapy or if individuals from different faiths respond differentially to Acceptance and Commitment Therapy. In addition, given the potential spiritual and religious undertones of this therapy, future studies need to determine if undergoing treatment via Acceptance and Commitment Therapy changes individuals' religious orientation or other characteristics related to spirituality and religiosity.

It is unclear why both active and passive responding correlated for older adults with extrinsic orientations only. Perhaps the effect we found in this study is not solely an age effect as much it is an interaction between age and social aspects of one's religion, that is, utilizing one's religious community for social support, one characteristic of individuals with an extrinsic religious orientation. Future studies could specifically focus on this interaction.

Our findings do show that older adults are more extrinsically religious than younger adults; at least that was the case with the adults in the current study. The older adult sample in our study, however,lived in a facility consisting of individuals of predominantly Jewish faith. There is some data that suggests those of Jewish faith, especially older adults of Jewish faith, develop a strong sense of community that serves as a strong sense of social support for them. Kakhnovets and Wolf (2011), for example, compared a younger, student sample and older, community sample, both of Jewish faith, on measures of ethnic identity, Jewish affiliation, and extrinsic versus intrinsic religiosity. For the younger population, mean age 18.98, Jewish affiliation was nota moderator between ethnic identity and spirituality, but Jewish affiliation was a moderator for the communitysample, mean age 36.54. In fact, as identity scores increased, spirituality scores didtoo.

Interestingly, for the community sample, affiliation moderated the relationship between ethnic identity and extrinsic religiosity but not intrinsic religiosity. This suggests that rather than using religion as meaning making (as one would expect for someone with an intrinsic religious orientation), attending services and using religion as a utilitarian approach may be a social activity that provides connections. Kakhnovets and Wolf (2011) hypothesized that younger adults might have competing activities that occur on the Sabbath, but older adults might attend services as a means of social contact. Older adults may engage in more religious activities than younger adults, primarily as a social means or way to stay connected with each other. Therefore, it makes sense that older adults, especially those with an extrinsic religious orientation, would exhibit differing coping skills than those with an intrinsic religious orientation. This is consistent with another study (Ysseldyk et al., 2011), which found that coping processes differ between those with high intrinsic versus those with high extrinsic religious orientation.

Some religious authorities might say that being extrinsically religious is an inferior form of religious orientation because of its focus on the external activities instead of the internal (presumably most spiritual) focus on meaning making. However,some research shows that extrinsic religious orientation is not an inferior religious orientation but rather a different, equal way to cope. Haber(2011), for example, explains that the "Hervuta method" is part of the Jewish tradition that does have an extrinsic orientation tone. The "Hervuta method" is the idea that each person has access to some truth and that in order to get closer to the "truth" we need to come together, hence being social. Furthermore, the role that social connectedness plays in a Jewish person's sense of coping may relate to the historical context of the Jewish community. An individual does not necessarily need faith but can identify themselves by participating in Jewish communal activities(Park, Jennings, Shin, Martin, &Roff, 2010), such that religious activities are meaningful because they provideindividualsthe opportunity to interact with others. Such support can be a coping mechanism to help adapt to stressful situationsand can increase one's quality of life. Indeed,Huang, Hsu, and Chen (2011),among others, found that religious involvements act as a support against mental health concerns such as depression and anxiety. Another study (Cheung &Kam, 2012), however, found that isolation can lead to religious faith, a contributor to resiliency. This study utilized older individuals in Honk Kong. Future research needs to explore cultural factors contributing to religious identity and overall resiliency and coping. In addition, future research needs to identify if there are factors (e.g., extrinsic versus intrinsic religious orientation) that might predict which individuals would most benefit from isolation versus socialization.

With the reconciliation between religious and mental health professionals, there has been a resurgence in research on coping among various religions. For example, Ong and Moschis (2009) revealed differences in use of emotion-focused coping strategies among three different religious groups (Buddhist, Hindu, and Muslim). Specifically, those who were the most religious used the least emotion-focused coping, though there was a potential ethnic culture confound.

Also, a study among Presbyterians showed a significant relationship between level of stress and use of both spiritual and non-spiritual coping strategies (Meisenhelder & Marcum, 2009). Not surprisingly, a study among Roman Catholics (Szewczyk & Weinmuller, 2006) indicated that those Roman Catholics who reported themselves engaged in religious activity also reported using positive religious coping strategies. In addition, a recent study (Khan, Watson, & Chen, 2012) revealed a positive relationship between Islamic identity and both extrinsic and intrinsic religious orientation as related to mental well-being.

The fact that the primary religion of the older adult population in this study is Jewish is a limitation of the study, but it also represents an opportunity for investigation and speculation. Despite the large amount of research on religion as a coping mechanism, there is little research regarding how religious affiliation impacts the coping process (Fischer et al., 2010). One theory describes how differences in individualistic and collectivist cultures, formed by certain religious aspects, can fuel certain coping skills. Fischer et al. (2010) compiled research that compared coping behaviors in both Christian and Muslim communities. Those who are Christian tend to be individualistic in nature, which means that those who follow this faith may handle stress via intrapersonal means. In contrast, Muslims tend to be from a collectivist culture and may therefore be interpersonal in their coping methods. In addition, research shows that the social identity of a group may be of a collective nature when the group has suffered a collective trauma (Fischer et al., 2010). The older adult population in our study was from two Jewish assisted living facilities and were all Jewish in faith, even if not actively practicing, and may have either had direct involvement with or have family members who were in the holocaust. As such, it is likely their cultural ethos is that of a collectivist culture.Interestingly, Fischer et al. (2010) hypothesized that those who are individualistic tend to exhibit intrinsic coping methods and those who are collectivist tend to exhibit extrinsic coping methods. This may be why our findings showed that the older adults were significantly more extrinsically religious than the younger adults.

Another limitationof our study was thatin addition to the mostly single religious faith of our older adult population, many of the older adults had to have the surveys read orally to them. This could have impacted the kinds of responses they were willing to provide. Furthermore, most of our participants were white females. Future research needs to investigate other ethnic groups to determine if results found in the current study are consistent across ethnic groups. Some studies have found that cultural factors may influence religious use and identification as well as serve as a means of coping (c.f., Williams, Keigher, Williams, 2012). Future research also needs to investigate supplementary relationships found in this study to determine whether they represent robust and real findings or spurious results. Some of these other findings in this study do seem reasonable. For instance, the correlations between intrinsic religious orientation and two scales of positive reinterpretation and growth and suppression of competing activities among older adults make sense. Individuals high in intrinsic religious orientation tend to make meaning out of events that occur to them (including difficult, traumatic events) and might behaviorally inhibit other activities while doing so. There is relatively recent evidence linking behavioral inhibition of activities with exposure to traumatic stressors (DePrince, Weinzierl, & Combs, 2009). Also, the correlation between planning and intrinsic religious orientation among younger adults may indicate that having religion as a focus of one's life lends itself to a prescribed path for where one's life ought to be heading. Although these findings are consistent with the general conceptualization of intrinsic and extrinsic religious orientation, additional data is necessary to provide support for these findings.

Finally, the fact that there were statistically significant correlations between the Religion Scale of the COPE and extrinsic religious orientation subscale of the Religious Orientation Scale for both older and younger adults and that both correlations were very high and similar in number provides validity to the instrument and to the findings in our study.Theoretically, individuals who are high in extrinsic religious orientation use religion and the social components of the faith as a means of coping. Thus, these correlations reveal that consistent relationship across both age groups.

In addition to the research and theoretical implications already discussed, results from the current study have significant clinical implications for both mental health and religious professionals. A large percentage of individuals seeking guidance on how to cope with life stressors utilize spiritual and religious activities. Clergy also face a large number of stressors, including guilt regarding personal time (especially among women), financial strain, marital discord, and child-related stress (especially among young pastors), and they experience a higher than average number of self-reported physical illnesses (Lee, 2007; LeGrand, Proeschold-Bell, James, & Wallace, 2013; Platt, &Moss, 2010;Proeschold-Bell, R. J., &LeGrand, 2010, 2012). It appears that clergy often feel overloaded by their work (Berry, Francis, Rolph, & Rolph, 2012) and that the stress and pressures that clergy experience directly relate to their health (Proeschold-Bell et al., 2011). Spiritual meaning (as well as relational processes) may impact how clergy respond to the stresses and pressures of their jobs (Cattich, 2012), and spirituality appears to have a significant effect on clergy quality of life (Darling, Hill, & McWey, 2004). Another study (Miner, Dowson, & Sterland, 2010) highlighted the role of an internal ministry orientation to their satisfaction with the ministry. Future research might want to look at coping and religious orientation among clergy. Results from the current study suggest that whether individuals (including clergy) seeking guidance have high intrinsic or extrinsic religiosity may impact their current style of coping. Assessment of an individual's current religiosity and style of coping may help mental health and religious professionals as they endeavor to assist individuals under their care.

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