The Many Methods of Religious Coping: Development and Initial Validation of the RCOPE

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The purpose of this study was to develop and validate a new theoretically based measure that would assess the full range of religious coping methods, including potentially helpful and harmful religious expressions. The RCOPE was tested on a large sample of college students who were coping with a significant negative life event. Factor analysis of the RCOPE in the college sample yielded factors largely consistent with the conceptualization and construction of the subscales. Confirmatory factor analysis of the RCOPE in a large sample of hospitalized elderly patients was moderately supportive of the initial factor structure. Results of regression analyses showed that religious coping accounted for significant unique variance in measures of adjustment (stress-related growth, religious outcome, physical health, mental health, and emotional distress) after controlling for the effects of demographics and global religious measures (frequency of prayer, church attendance, and religious salience). Better adjustment was related to a number of coping methods, such as benevolent religious reappraisals, religious forgiveness/purification, and seeking religious support. Poorer adjustment was associated with reappraisals of God's powers, spiritual discontent, and punishing God reappraisals. The results suggest that the RCOPE may be useful to researchers and practitioners interested in a comprehensive assessment of religious coping and in a more complete integration of religious and spiritual dimensions in the process of counseling. J Clin Psychol 56: 519–543, 2000.

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Introduction

In recent years, investigators have found significant links between religious and spiritual variables and mental health (e.g., Bergin, Masters, & Richards, 1987; Koenig, 1997; Schumaker, 1992). These findings suggest that religiousness and spirituality represent potentially valuable resources for individuals in counseling.[1] In fact, a number of researchers and practitioners have called for greater sensitivity to, and integration of religion and spirituality into assessment and counseling (e.g., Lovinger, 1984; Propst, 1988; Richards & Bergin, 1997; Shafranske, 1996). There is, however, a clear need for clinically relevant theoretical frameworks to advance research and practice in this area (Hood, Spilka, Hunsberger, & Gorsuch, 1996; Worthington, 1989). Coping theory represents one promising perspective from which to understand, study, and work with religious issues (Pargament, 1997).

When asked how they cope with their most stressful situations, many people make mention of religion. Among some groups, particularly the elderly, minorities, and individuals facing life-threatening crises, religion is cited more frequently than any other resource for coping (e.g., Bulman & Wortman, 1977; Conway, 1985–1986). Furthermore, indices of religious coping have been associated with a variety of salient outcomes, including lower rates of depression (Koenig, et al., 1992), better mental-health status (Pargament et al., 1994), better physical health (Harris et al., 1995; McIntosh & Spilka, 1990; Pressman, Lyons, Larson, & Strain, 1990), stress-related growth (Park & Cohen, 1993), spiritual growth (Pargament et al., 1990), and reduced rates of mortality (Oxman, Freeman, & Manheimer, 1995; Zuckerman, Kasl, & Ostfeld, 1984). These effects remain significant after controlling for the effects of socio-demographic variables, global religious measures, and nonreligious coping measures (e.g., Koenig et al., 1995; Pargament, 1997).

What is it about religious coping that affects the outcomes of major life stressors? The answer to this question is not clear, in part because the measurement of religious coping is still in its early stages. A number of approaches have been taken to assessing religious coping. While several of these approaches have demonstrated reliability and validity, each has its particular limitations. In this paper, we report on the development and initial validation of a measure of religious coping (the RCOPE), one that could lead to a sharper understanding of the roles of religion in the coping process and a better integration of religious issues into assessment, counseling, and educational activities.

Rationale Underlying the Development of the RCOPE

Four underlying assumptions guided the development of the RCOPE.

Theoretically Based and Functionally Oriented

Measures of religious coping should be grounded theoretically in a functional view of religion and the roles it plays in coping. In the past, global indicators of religiousness (e.g., frequency of prayer, congregational attendance) have been used to measure religious coping (Bahr & Harvey, 1979; Sherkat & Reed, 1992). Although this method of

[1] The term "religion" is used here in its classic sense—a broad domain that includes individual and institutional expressions, serves a variety of purposes, and may play potentially helpful and/or harmful roles in peoples' lives (Pargament, 1997; Zinnbauer, Pargament, & Scott, in press). "Spirituality" is used here to refer to the key function of religion—the effort to find, sustain, and transform a relationship with the sacred.

assessment is efficient, it leaves important questions unanswered about the functional roles of religion in coping. It is not enough to know that an individual prays, attends church, or watches religious television. Measures of religious coping should specify *how* the individual is making use of religion to understand and deal with stressors. Thinking functionally should lead to stronger predictions of outcomes, easier interpretation of significant and nonsignificant results, and advances in our understanding of the ways religion expresses itself in critical life situations.

Religious scholars long have debated the most important functions of religion. From our perspective, there is no need to choose. Religion serves a variety of purposes in day-to-day living and in crisis. For the purposes of our research, we identified five key religious functions:

1. Meaning. According to theorists such as Clifford Geertz (1966), religion plays a key role in the search for meaning. In the face of suffering and baffling life experiences, religion offers frameworks for understanding and interpretation.
2. Control. Other theorists, such as Erich Fromm (1950), have stressed the role of religion in the search for control. Confronted with events that push the individual beyond his/her own resources, religion offers many avenues to achieve a sense of mastery and control.
3. Comfort/Spirituality. According to the classic Freudian (1927/1961) view, religion is designed to reduce the individual's apprehension about living in a world in which disaster can strike at any moment. It is difficult, however, to separate comfort-oriented religious-coping strategies from methods that may have a genuine spiritual function. From the religious perspective, spirituality, or the desire to connect with a force that goes beyond the individual, is the most basic function of religion (Johnson, 1959).
4. Intimacy/Spirituality. Sociologists such as Durkheim (1915) generally have emphasized the role of religion in facilitating social cohesiveness. Religion is said to be a mechanism of fostering social solidarity and social identity. Intimacy with others, however, often is encouraged through spiritual methods, such as offers of spiritual help to others and spiritual support from clergy or members. Thus, again, it is difficult to separate out many of the methods that foster intimacy from methods that foster closeness with a higher power (Buber, 1970).
5. Life Transformation. Theorists traditionally have viewed religion as conservational in nature—helping people maintain meaning, control, comfort, intimacy, and closeness with God. However, religion also may assist people in making major life transformations; that is, giving up old objects of value and finding new sources of significance (Pargament, 1997).

Religious coping methods were defined with respect to each of these five basic religious functions (see Table 1). For example, meaning in stressful situations can be sought in several religious ways: redefinition of the stressor as an opportunity for spiritual growth (Benevolent Religious Reappraisal), redefinition of the situation as a punishment from God (Punishing God Reappraisal), redefinition of the situation as the work of the Devil (Demonic Reappraisal), and questioning God's power to affect the situation (Reappraisal of God's Powers). We recognized, however, that any form of religious coping may serve more than one purpose. Thus, we did not expect to find five factors of religious coping that correspond to these five religious functions.

Table 1
RCOPE Subscales and Items and Definitions of Religious Coping Methods

Religious Methods of Coping to Find Meaning
Benevolent Religious Reappraisal—redefining the stressor through religion as benevolent and potentially beneficial
*1. Saw my situation as part of God's plan.
*2. Tried to find a lesson from God in the event.
*3. Tried to see how God might be trying to strengthen me in this situation.
4. Thought that the event might bring me closer to God.
5. Tried to see how the situation could be beneficial spiritually.
Punishing God Reappraisal—redefining the stressor as a punishment from God for the individual's sins
*1. Wondered what I did for God to punish me.
*2. Decided that God was punishing me for my sins.
*3. Felt punished by God for my lack of devotion.
4. Wondered if God allowed this event to happen to me because of my sins.
5. Wondered whether God was punishing me because of my lack of faith.
Demonic Reappraisal—redefining the stressor as an act of the Devil
*1. Believed the devil was responsible for my situation.
*2. Felt the situation was the work of the devil.
3. Felt the devil was trying to turn me away from God.
*4. Decided the devil made this happen.
5. Wondered if the devil had anything to do with this situation.
Reappraisal of God's Powers—redefining God's power to influence the stressful situation
*1. Questioned the power of God.
*2. Thought that some things are beyond God's control.
*3. Realized that God cannot answer all of my prayers.
4. Realized that there were some things that even God could not change.
5. Felt that even God has limits.
Religious Methods of Coping to Gain Control
Collaborative Religious Coping—seeking control through a partnership with God in problem solving
*1. Tried to put my plans into action together with God.
*2. Worked together with God as partners.
*3. Tried to make sense of the situation with God.
4. Felt that God was working right along with me.
5. Worked together with God to relieve my worries.
Active Religious Surrender—an active giving up of control to God in coping
*1. Did my best and then turned the situation over to God.
*2. Did what I could and put the rest in God's hands.
*3. Took control over what I could, and gave the rest up to God.
4. Tried to do the best I could and let God do the rest.
5. Turned the situation over to God after doing all that I could.
Passive Religious Deferral—passive waiting for God to control the situation
*1. Didn't do much, just expected God to solve my problems for me.
*2. Didn't try much of anything; simply expected God to take control.
*3. Didn't try to cope: only expected God to take my worries away.
4. Knew that I couldn't handle the situation, so I just expected God to take control.
5. Didn't try to do much; just assumed God would handle it.
Pleading for Direct Intercession—seeking control indirectly by pleading to God for a miracle or divine intercession
*1. Pleaded with God to make things turn out okay.
*2. Prayed for a miracle.
*3. Bargained with God to make things better.
4. Made a deal with God so that he would make things better.
5. Pleaded with God to make everything work out.

(continued)

Table 1 continued

Religious Methods of Coping to Gain Control (continued)
Self-Directing Religious Coping—seeking control directly through individual initiative rather than help from God
*1. Tried to deal with my feelings without God's help.
*2. Tried to make sense of the situation without relying on God.
*3. Made decisions about what to do without God's help.
4. Depended on my own strength without support from God.
5. Tried to deal with the situation on my own without God's help.
Religious Methods of Coping to Gain Comfort and Closeness to God
Seeking Spiritual Support—searching for comfort and reassurance through God's love and care
*1. Sought God's love and care.
*2. Trusted that God would be by my side.
*3. Looked to God for strength, support, and guidance.
4. Trusted that God was with me.
5. Sought comfort from God.
Religious Focus—engaging in religious activities to shift focus from the stressor
*1. Prayed to get my mind off of my problems.
*2. Thought about spiritual matters to stop thinking about my problems.
*3. Focused on religion to stop worrying about my problems.
4. Went to church to stop thinking about this situation.
5. Tried to get my mind off my problems by focusing on God.
Religious Purification—searching for spiritual cleansing through religious actions
*1. Confessed my sins.
*2. Asked forgiveness for my sins.
*3. Tried to be less sinful.
4. Searched for forgiveness from God.
5. Asked for God to help me be less sinful.
Spiritual Connection—experiencing a sense of connectedness with forces that transcend the individual
*1. Looked for a stronger connection with God.
*2. Sought a stronger spiritual connection with other people.
*3. Thought about how my life is part of a larger spiritual force.
4. Tried to build a strong relationship with a higher power.
5. Tried to experience a stronger feeling of spirituality.
Spiritual Discontent—expressing confusion and dissatisfaction with God's relationship to the individual in the stressful situation
*1. Wondered whether God had abandoned me.
*2. Voiced anger that God didn't answer my prayers.
*3. Questioned God's love for me.
4. Wondered if God really cares.
5. Felt angry that God was not there for me.
Marking Religious Boundaries—clearly demarcating acceptable from unacceptable religious behavior and remaining within religious boundaries
*1. Avoided people who weren't of my faith.
*2. Stuck to the teachings and practices of my religion.
*3. Ignored advice that was inconsistent with my faith.
4. Tried to stick with others of my own faith.
5. Stayed away from false religious teachings.
Religious Methods of Coping to Gain Intimacy with Others and Closeness to God
Seeking Support from Clergy or Members—searching for comfort and reassurance through the love and care of congregation members and clergy
*1. Looked for spiritual support from clergy.
*2. Asked others to pray for me.

(continued)

Table 1 continued

Religious Methods of Coping to Gain Intimacy with Others and Closeness to God (continued)
*3. Looked for love and concern from the members of my church.
4. Sought support from members of my congregation.
5. Asked clergy to remember me in their prayers.
Religious Helping—attempting to provide spiritual support and comfort to others
*1. Prayed for the well-being of others.
*2. Offered spiritual support to family or friends.
*3. Tried to give spiritual strength to others.
4. Tried to comfort others through prayer.
5. Tried to provide others with spiritual comfort.
Interpersonal Religious Discontent—expressing confusion and dissatisfaction with the relationship of clergy or members to the individual in the stressful situation
*1. Disagreed with what the church wanted me to do or believe.
*2. Felt dissatisfaction with the clergy.
*3. Wondered whether my church had abandoned me.
4. Felt my church seemed to be rejecting or ignoring me.
5. Wondered whether my clergy was really there for me.
Religious Methods of Coping to Achieve a Life Transformation
Seeking Religious Direction—looking to religion for assistance in finding a new direction for living when the old one may no longer be viable
*1. Asked God to help me find a new purpose in life.
*2. Prayed to find a new reason to live.
*3. Prayed to discover my purpose in living.
4. Sought new purpose in life from God.
5. Looked to God for a new direction in life.
Religious Conversion—looking to religion for a radical change in life
*1. Tried to find a completely new life through religion.
*2. Looked for a total spiritual reawakening.
*3. Prayed for a complete transformation of my life.
4. Tried to change my whole way of life and follow a new path—God's path.
5. Hoped for a spiritual rebirth.
Religious Forgiving—looking to religion for help in shifting from anger, hurt, and fear associated with an offense to peace
*1. Sought help from God in letting go of my anger.
*2. Asked God to help me overcome my bitterness.
*3. Sought God's help in trying to forgive others.
4. Asked God to help me be more forgiving.
5. Sought spiritual help to give up my resentments.

*indicates item is on the 3-item version of the subscale.

Open to the Negative as well as the Positive Side of Religion

Although the concept of coping has a positive connotation, coping can be ineffective as well as effective. Religion also has its darker side. Measures of religious coping generally have focused on the positive dimension (e.g., Boudreaux, Catz, Ryan, Amaral-Melendez, & Brantley, 1995; Carver, Scheier, & Weintraub, 1989). In the spirit of comprehensiveness and scientific openness, however, it is important to consider potentially dysfunctional forms of religious coping. Table 1 specifies several methods of religious coping that may be ineffective in dealing with stressful situations. There is, for example, some evidence to suggest that Punishing God Reappraisals, Demonic Reappraisals, Spiritual

Discontent, Interpersonal Religious Discontent, and Pleading for Direct Intercession are associated with greater distress, at least for the short term (Pargament, 1997; Pargament, Zinnbauer et al., 1998).

Comprehensive

Part of religion's power lies in its multifunctional character and its ability to offer diverse methods of coping for diverse situations. Unfortunately, the multifunctional nature of religion often is obscured in the general coping literature. When it is included in general coping measures, religion typically is assessed by one or two items (Keefe, 1992; Lazarus & Folkman, 1984; McCubbin, Dahl, Lester, Benson, & Robertson, 1976). For example, Lazarus and Folkman's (1984) widely used, 67-item Ways of Coping Scale includes two explicitly religious items, "found new faith" and "I prayed." However, the special contribution religion may make to coping cannot be assessed in this approach because the small number of religious items typically are embedded in broader factor-analytically derived dimensions. In the case of the Ways of Coping Scale, the two religious items become part of a larger "Positive Reappraisal" factor (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986).

Measures of religious coping should assess the wide range of religious coping activities. Of course, it would be practically unfeasible to develop scales that reflect methods of coping with all situations by all religious groups (e.g., smoking lodges among American Indians, sitting shiva for Jews) in one instrument. It is possible, though, to assess methods of religious coping that are applicable to the broad mainstream of Americans from Judeo-Christian traditions.

The religious coping methods defined in Table 1 are multidimensional; they run counter to common stereotypes about religion as simply a psychological defense or passive form of coping (see Pargament & Park, 1995). They encompass active, passive, and interactive coping methods. They include problem-focused and emotion-focused approaches. They cover cognitive, behavioral, interpersonal, and spiritual domains. Our goal here, however, was not to identify a few basic higher-order religious coping factors. Rather, we were interested in assessing comprehensively and in some detail the many methods of religious coping.

Empirically Based, but Clinically Valid and Meaningful

To the extent that it is possible, measures of religious coping should build on previous empirical studies and established scales. Whenever possible, we have drawn on items from existing religious coping scales (e.g., Pargament et al., 1988, 1990; Pargament, Zinnbauer et al., 1998). To maximize its clinical utility, the instrument also should incorporate coping methods and items that are clinically meaningful and strongly linked to descriptions of people under stress about the ways they use religion as a coping resource. A combination of theoretically, clinically, and empirically derived items are best suited to this purpose.

The Present Study

In the present study, we report on the results of our effort to develop and validate initially a comprehensive measure of religious coping. Specifically, we examine evidence of internal consistency and factor-analytic support for the subscales. Working with a college-student sample experiencing major life stressors, we assess the intercorrelations between the RCOPE and diverse criteria of adjustment to the stressors, including measures of

physical health, mental health, stress-related growth, and spiritual outcomes. We also examine evidence of incremental validity (cf., Gorsuch, l984); that is, the degree to which the RCOPE predicts adjustment to life crises beyond the effects of demographic variables and global religious measures. In addition, we assess the comparability of the factor structure of the RCOPE within a sample at the other end of the adult life span: hospitalized older adults confronting serious medical illnesses. Finally, as a test of the discriminant validity of the RCOPE, we compare the subscales scores of the college students and the hospitalized older adults. Several researchers have found higher levels of religiousness and religious coping among older than younger persons (e.g., Ferraro & Koch, 1994; Gurin, Veroff, & Feld, 1960) and among people facing more-serious than less-serious life events (e.g., Ellison & Taylor, 1996; Mattlin, Wethington, & Kessler, 1990). Thus, we expected hospitalized older adults to report generally higher levels of religious coping than the college sample.

Methods

Participants and Procedures

College Sample. A total of 540 college students completed the study. Students participated voluntarily and received extra credit towards their introductory psychology course for participating. After a brief explanation of the project, questionnaires were distributed to interested students during class lectures.

The sample was primarily white (93%), single (99%), and female (69%). The average age of the participants, most of who were college freshmen (70%), was 19.0 years (range from 18 to 38).

Respondents reportedly experienced a variety of serious negative events within the last three years. The most commonly reported events were: death of a family member (22.1%), death of a friend (14.1%), romantic relationship problems (12.2%), serious illness of a family member (9.3%), serious illness of self (8%), and separation, divorce, or other family conflict (7%). In terms of the rated impact of the event, 59.7% of the sample rated their event as extremely negative, 3l.9% as moderately negative, 5.9% as somewhat negative, and 2.4% as slightly negative.

The sample was primarily Catholic (45%) and Protestant (41%). The large majority of the sample indicated at least some level of religious involvement. Only 6.7% reported that they never spent time in private religious activities (e.g., prayer, meditation, Bible study). Other frequencies of private religious activities were: 25% (a few times a month), 17.6% (once a week), 7.4% (twice a week), 15.7% (daily), and 27.4% (more than once a day). Only 6.1% stated that they never attended church or religious meetings. Other frequencies for religious attendance were: 19.3% (once a year or less), 25.6% (a few times a year), 33% (a few times a month), 10.7% (once a week), and 5.2% (more than once a week). With respect to their serious negative event, only 14.2% indicated that religion was not at all involved in understanding or dealing with the event in any way. The other percentages for the degree of religious involvement in coping with the event were: l3.6% (slightly), l7.5% (somewhat), 25.1% (moderately), and 29.6% (considerably).[2]

Hospital Sample. Data also were collected from a second sample consisting of 551 elderly hospital patients. Data from these participants provided a sample with which the

[2] A more complete description of the demographic characteristics of the sample is available from the first author.

factor structure of the RCOPE could be confirmed. The only findings from these data presented here are the results of a confirmatory factor analysis of the RCOPE, and a comparison of the two samples on their RCOPE scores. Complete results of a second study with this sample are presented in Koenig, Pargament, & Nielsen (1998).

Participants in the second study were identified from computerized lists of hospital admissions and screened by research assistants to determine their eligibility for the study. The eligible patients ($N = 735$) were visited in their hospital rooms by research assistants, and those who consented to participate were interviewed in their rooms.

A total of 184 patients were excluded for medical reasons (e.g., too ill or cognitively impaired to participate) as well as practical constraints (e.g., patient was discharged from hospital, undergoing tests, asleep, or declined to participate). The overall response rate was 75%.

The majority of patients had at least a moderately severe medical illness (71%, $M = 3.01$) as assessed by the interviewer-rated American Society of Anesthesiologists' severity of illness (ASA) scale, with categories ranging from 0 (no or minimally severe illness) to 5 (very severe illness) (American Association of Anesthesiologists, 1963). Sixty three percent had at least five active medical diagnoses at the time of admission ($M = 5.30$) according to a medical records review for the categories of illness based on the ICD-9 manual (ICD-9, 1989). The most common medical diagnoses were diseases of the heart and blood vessels (41%), infectious and parasitic diseases (13%), and diseases of the digestive system (11%).

Fifty-two percent of the sample was male, 62% were white, and the average age of patients was 68.4 years (range = 55–97). Seventy-two percent had at least a high school education. In response to the question, "Other than going to religious meetings, how important is religion to you?", 83% indicated that religion was very important to them.

Measures

College Sample

Background Information. Participants responded to several questions regarding demographic information. In addition, they were asked to provide information and ratings about the negative life event they had experienced, including the nature of the event, the rated impact of the event, and the extent to which their religion was involved in dealing with the event.

Global Religious Measures. Three items, traditionally used in the literature (Koenig, 1997), were used to assess participation in religious activities. Participants indicated how often they attended religious services (responses ranged from 1 "never" to 6 "more than once a week"), and how often they prayed or meditated privately (responses ranged from 1 "rarely or never" to 6 "more than once a day").

Religious Coping. The 21 subscales of the RCOPE were used to assess the degree to which various types of religious coping were involved in dealing with the most serious negative event they had experienced in the past three years. Some of the items were adapted from existing scales, and others were generated from the clinical literature and from interviews with individuals facing a variety of life stressors. Approximately eight items were adapted or created for each scale. Feedback on the items was obtained from ten graduate psychology students who were asked to sort the items into the appropriate subscales. Items that were not phrased clearly or classified reliably by 80% of the raters

were dropped. Raters had close to 100% agreement in classification for all items retained for the final scale. Each of the 21 subscales consisted of 5 items to which participants responded on a 4-point Likert scale ranging from 0 "not at all" to 3 "a great deal." The items are listed by subscale in Table 1. The instructions for completing the items were adapted from Carver et al. (1989):

> The following items deal with ways you coped with the negative event in your life. There are many ways to try to deal with problems. These items ask what you did to cope with this negative event. Obviously different people deal with things in different ways, but we are interested in how you tried to deal with it. Each item says something different about a particular way of coping. We want to know to what extent you did what the item says. *How much or how frequently*. Don't answer on the basis of what worked or not—just whether or not you did it. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

Measures of Adjustment

Physical Health. Physical health was assessed using a measure of physical symptoms developed by Moos, Cronkite, Billings, and Finney (1986). Participants indicated whether they had experienced any of 12 physical symptoms within the past month. Examples of physical symptoms included in the measure are "headaches" and "poor appetite."

General Health Questionnaire (GHQ). The GHQ (Goldberg, 1978) was used to assess recent mental health status. The GHQ consists of 12 items assessing the degree to which the respondent has experienced a list of psychosomatic symptoms in the past week, such as "Have you recently lost much sleep over worry" and "Have you been able to enjoy your normal day-to-day activities." Participants respond using a 4-point Likert format with responses ranging from 1 "less so than usual" to 4 "much more than usual."

Emotional Distress. Participants responded to two items indicating the amount of emotional distress (sadness, anxiety, anger) that they experienced immediately following the event, and the amount of distress they currently were experiencing. Responses for both items ranged from 0 "none" to 10 "a great deal."

Stress-Related Growth. Park, Cohen, and Murch's (1996) measure of Stress-Related Growth was used to assess the potentially positive outcomes of negative life events. The measure includes 15 items, such as "I learned to find more meaning in life" and "I learned to reach out and help others." Participants responded on a 3-point Likert scale ranging from 0 "not at all" to 2 "a great deal."

Religious Outcome. A 3-item scale of Religious Outcome was used to assess the extent to which participants experienced positive religious changes, such as growing closer to God or the church, as a result of coping with negative life events (Pargament et al., 1990). Participants responded to each item on a 3-point Likert scale ranging from 0 "not at all" to 2 "a great deal."

Hospital Sample

Religious Coping. Religious coping was assessed to determine the degree to which patients made use of various religious methods of coping with their illnesses. To limit the length of the interview for the patients, a shortened version of the RCOPE (three items

per subscale) was used. The items used in the shorter version were chosen on purely subjective grounds because data from the hospital and college samples were collected concurrently, and, therefore, there was no empirical evidence on which to base the choice of items for the shorter version. The items included in the hospital sample are indicated by an asterisk in the list in Table 1.

Results

College Sample

Exploratory Factor Analysis. All 105 items from the 21 subscales were entered into an exploratory factor analysis using principal components extraction and oblique rotation. The oblique rotation was chosen because the various religious coping dimensions were expected to be correlated. The factor solution was determined by the number of factors generated with eigenvalues greater than 1, as well as by theoretical considerations. Seventeen factors had an eigenvalue greater than one. We compared the 17-factor solution to solutions with larger and smaller numbers of factors. Larger factor solutions were rejected because they included single-item factors. The 17-factor solution also appeared to be more meaningful theoretically than smaller factor solutions that merged religious coping methods in ways that were difficult to interpret.

The 17-factor solution accounted for 62.7% of the variance. Factor correlations ranged from .00 to .48. Examination of the pattern of factor loadings revealed five items that had factor loadings less than .30. These items were dropped and the remaining 100 items were subjected to another factor analysis. Results of this analysis were essentially the same as the original solution. Each item loaded highest on its respective factor. There were no crossloadings of items ($>.30$) on other factors, with the exception of one item.

A summary of the results of this factor analysis is presented in Table 2. These results were largely consistent with the 21 original, theoretically developed subscales. Eight of the original 21 subscales were retained in their original form after the factor analysis. Two of the remaining factors were formed by combining two conceptually similar subscales. For example, the five Religious Purification items and the five Religious Forgiveness items loaded on one factor, as did the five Seeking Religious Direction items and the five Religious Conversion items. The remaining factors consisted of items from more than one subscale that combined in conceptually meaningful ways. For example, low scores on the five Self-Directing Religious Coping items loaded on the same factor as two of the Collaborative Religious Coping items and one of the Seeking Spiritual Support items. Overall, the factor analytic results were supportive of the theoretical framework underlying the development of the scale.

Internal-Consistency Results. Results of the factor analysis were used to create subscales and estimates of Cronbach's alpha were calculated for the factor analytically derived subscales. Reliability estimates were generally high, indicating good internal consistency (see Table 3). Alpha was .80 or greater for all but two scales (Marking Religious Boundaries and Reappraisal of God's Power). Therefore, the factor analytically derived subscales were retained for further analyses.

Descriptive Statistics. Descriptive statistics for all measures are presented in Table 3. In general, positive aspects of religious coping were used more frequently than the negative aspects. The most commonly used religious-coping methods in this sample were the Collaborative Religious Coping factor ($M = 1.77$, $S.D. = .76$) and the Benevolent Reli-

Table 2
Factor Loadings from Exploratory and Confirmatory Factor Analyses in Student and Hospital Samples

	Exploratory Factor Loading Student Sample[a]	Confirmatory Factor Loading Hospital Sample[b]
Factor 1—Benevolent Religious Reappraisal		
Benevolent Religious Reappraisal 2	.570	1.000
Benevolent Religious Reappraisal 3	.554	1.040
Benevolent Religious Reappraisal 1	.452	.744
Seeking Spiritual Support 2	.452	.616
Benevolent Religious Reappraisal 5	.408	
Seeking Spiritual Support 4	.346	
Collaborative Religious Coping 3	.344	.819
Benevolent Religious Reappraisal 4	.334	
Seeking Spiritual Support 5	.323	
Factor 2—Punishing God Reappraisal		
Punishing God Reappraisal 4	.866	
Punishing God Reappraisal 2	.811	1.000
Punishing God Reappraisal 3	.763	.972
Punishing God Reappraisal 5	.745	
Punishing God Reappraisal 1	.654	1.148
Factor 3—Demonic Reappraisal		
Demonic Reappraisal 4	−.871	1.000
Demonic Reappraisal 1	−.857	1.134
Demonic Reappraisal 2	−.830	.922
Demonic Reappraisal 5	−.694	
Demonic Reappraisal 3	−.613	
Factor 4—Reappraisal of God's Powers		
Reappraisal of God's Power 2	.825	1.000
Reappraisal of God's Power 4	.789	
Reappraisal of God's Power 5	.582	
Reappraisal of God's Power 3	.449	.982
Factor 5—Collaborative Religious Coping		
Low Self-Directing Religious Coping 4	.725	
Low Self-Directing Religious Coping 2	.711	
Low Self-Directing Religious Coping 5	.663	
Seeking Spiritual Support 3	.620	
Low Self-Directing Religious Coping 1	.539	
Collaborative Religious Coping 5	.379	
Collaborative Religious Coping 2	.369	
Low Self-Directing Religious Coping 3	.406	
Factor 6—Active Religious Surrender		
Active Religious Surrender 4	.718	
Active Religious Surrender 3	.678	1.000
Active Religious Surrender 5	.642	
Active Religious Surrender 2	.618	1.015
Active Religious Surrender 1	.581	1.000
Factor 7—Passive Religious Deferral		
Passive Religious Deferral 2	−.728	1.000
Passive Religious Deferral 5	−.680	
Passive Religious Deferral 1	−.664	1.053
Passive Religious Deferral 4	−.618	
Passive Religious Deferral 3	−.402	1.141

(continued)

Table 2 continued

	Exploratory Factor Loading Student Sample[a]	Confirmatory Factor Loading Hospital Sample[b]
Factor 8—Pleading for Direct Intercession		
Pleading for Direct Intercession 1	−.684	1.000
Pleading for Direct Intercession 3	−.684	.646
Pleading for Direct Intercession 4	−.610	
Pleading for Direct Intercession 5	−.570	
Pleading for Direct Intercession 2	−.445	.935
Factor 9—Religious Focus		
Religious Focus 2	.621	1.000
Religious Focus 1	.539	.992
Religious Focus 5	.498	
Religious Focus 3	.454	1.015
Religious Focus 4	.415	
Factor 10—Religious Purification/Forgiveness		
Religious Purification 4	.629	
Religious Purification 2	.604	
Religious Purification 5	.597	1.000
Religious Purification 1	.533	1.164
Religious Forgiveness 3	.531	1.144
Religious Forgiveness 4	.505	
Religious Forgiveness 2	.429	1.247
Religious Forgiveness 1	.387	1.240
Religious Purification 3	.364	.907
Religious Forgiveness 5	.306	
Factor 11—Spiritual Connection		
Spiritual Connection 3	.382	
Spiritual Connection 5	.378	
Spiritual Connection 4	.374	
Factor 12—Spiritual Discontent		
Spiritual Discontent 4	.747	
Spiritual Discontent 5	.678	
Spiritual Discontent 3	.674	1.000
Spiritual Discontent 1	.605	1.046
Spiritual Discontent 2	.598	.579
Reappraisal of God's Power 1	.377	.435
Factor 13—Marking Religious Boundaries		
Marking Religious Boundaries 2	.435	
Marking Religious Boundaries 3	.423	
Marking Religious Boundaries 5	.422	
Marking Religious Boundaries 1	.329	
Factor 14—Seeking Support from Clergy/Members		
Seeking Support from Clergy or Members 1	−.828	1.000
Seeking Support from Clergy or Members 5	−.789	
Seeking Support from Clergy or Members 4	−.721	
Seeking Support from Clergy or Members 3	−.706	.906
Seeking Support from Clergy or Members 2	−.592	.841

(continued)

Table 2 continued

	Exploratory Factor Loading Student Sample[a]	Confirmatory Factor Loading Hospital Sample[b]
Factor 15—Religious Helping		
Religious Helping 5	.785	
Religious Helping 3	.764	1.000
Religious Helping 2	.758	1.030
Religious Helping 4	.570	
Spiritual Connection 2	.391	1.019
Religious Helping 1	.331	.674
Factor 16—Interpersonal Religious Discontent		
Interpersonal Religious Discontent 3	.741	1.000
Interpersonal Religious Discontent 5	.701	
Interpersonal Religious Discontent 2	.624	2.927
Interpersonal Religious Discontent 4	.615	
Interpersonal Religious Discontent 1	.481	2.619
Factor 17—Religious Direction/Conversion		
Seeking Religious Direction 5	−.762	
Seeking Religious Direction 1	−.745	1.000
Seeking Religious Direction 4	−.727	
Seeking Religious Direction 2	−.701	.921
Religious Conversion 3	−.665	1.034
Religious Conversion 1	−.658	.947
Seeking Religious Direction 3	−.638	.832
Religious Conversion 2	−.606	.970
Religious Conversion 4	−.459	
Religious Conversion 5	−.337	

[a]Factor loading from exploratory factor analysis (principal factors with oblimin rotation) using college sample.
[b]Factor loading from lambda-*x* matrix from maximum likelihood confirmatory factor analysis (LISREL VII) using hospital sample.

gious Reappraisal factor ($M = 1.52$, $S.D. = .80$), while the least commonly used were Demonic Reappraisal ($M = .27$, $S.D. = .55$) and Interpersonal Religious Discontent ($M = .28$, $S.D. = .49$).

Regression Analyses. Hierarchical regression analyses were conducted to determine the unique variance in adjustment measures accounted for by the RCOPE factors beyond the effects of demographics and global religious measures. Only R^2 values for the entire block of RCOPE factors will be discussed here. These results are presented in Table 4.

Religious Coping and Demographic Variables. The first set of analyses evaluated the unique variance in adjustment measures accounted for by religious coping beyond the effects of demographic variables. Gender was the only demographic variable used in these analyses as it was the only one significantly related to adjustment. Gender accounted for significant variance (1–5%) in all measures of adjustment with the exception of GHQ scores. The RCOPE scales explained significant unique variance in all measures of adjustment, with ΔR^2 values ranging from .09 (Emotional Distress, Physical Health, and GHQ scores) to .61 (Religious Outcome).

Table 3
Descriptive Statistics for Adjustment and Religious Measures—College Sample

Adjustment Measures	Alpha	Mean	SD	Obs. Range
Physical Health	.78	18.61	3.01	9–24
GHQ	.86	30.37	6.06	13–48
Distress at time of event		8.30	1.98	0–10
Distress now		3.75	2.58	0–10
Stress-Related Growth	.90	18.41	7.47	0–30
Religious Outcome	.85	2.86	2.01	0–6

Global Religious Measures	Mean	SD	Obs. Range
Freq. of church attendance	3.61	1.23	1–6
Freq. of prayer	3.17	1.74	1–6
Self-rated religiousness	2.39	.63	1–3

RCOPE Subscales

Negative Religious Coping Scales	Items	Alpha	Mean	SD	Obs. Range
Spiritual Discontent	6	.88	.50	.66	0–3.0
Demonic Reappraisal	5	.90	.27	.55	0–3.0
Passive Religious Deferral	5	.83	.48	.58	0–3.0
Interpersonal Religious Discontent	5	.82	.28	.49	0–3.0
Reappraisal of God's Powers	4	.78	.98	.79	0–3.0
Punishing God Reappraisal	5	.92	.56	.76	0–3.0
Pleading for Direct Intercession	5	.84	1.25	.82	0–3.0
Positive Religious Coping Scales					
Religious Purification/Forgiveness	10	.93	1.14	.81	0–3.0
Religious Direction/Conversion	10	.94	.71	.74	0–3.0
Religious Helping	6	.90	1.16	.83	0–3.0
Seek Support Clergy/Members	5	.90	.74	.84	0–3.0
Collaborative Religious Coping	8	.89	1.77	.76	0–3.0
Religious Focus	5	.84	.87	.69	0–3.0
Active Religious Surrender	5	.92	1.03	.84	0–3.0
Benevolent Religious Reappraisal	8	.91	1.52	.80	0–3.0
Spiritual Connection	3	.81	1.09	.86	0–3.0
Marking Religious Boundaries	4	.61	.89	.66	0–3.0

Religious Coping and Global Religious Measures. The second set of analyses evaluated the unique variance in adjustment accounted for by religious coping beyond the effects of global religious measures. Gender was controlled for on the first step, followed by global religious measures, and then religious coping methods. The religious coping factors were entered next and accounted for significant amounts of unique variance in all measures of adjustment. Religious coping explained between 6% (GHQ) and 21% (Religious Outcome) of the variance in adjustment.

To assess the unique effects of the global religious measures, the order of entry was reversed so that religious-coping methods were entered into the equation before global religious measures. In this analysis, the global measures added significant unique variance only to the prediction of Religious Outcome ($\Delta R^2 = .02$).

Table 4
Hierarchical Regression Analyses: Unique Effects (ΔR^2) of Gender, Global Religious Measures (GRM), and Religious Coping Methods—College Sample

Unique Effects	Stress-Rel. Growth	Religious Outcome	Physical Health	GHQ	Distress at Time of Event	Distress Now
Gender	.03***	.01*	.05***	.01	.02**	.03***
RCOPE	.24***	.61***	.10***	.09**	.09**	.09**
RCOPE after Controlling for Gender and GRM	.19***	.21***	.09**	.06**	.08**	.08**
GRM after Controlling for Gender and RCOPE	.00	.02***	.00	.01	.01	.01
Overall	.27***	.65***	.15***	.11***	.12***	.13***

*$p < .05$; **$p < .01$; ***$p < .001$.

Intercorrelations with Adjustment Measures. Correlations between RCOPE factor subscales and adjustment measures are presented in Table 5. The religious-coping scales were correlated most consistently and strongly with Stress-Related Growth and Religious Outcome. However, small but significant correlations were found between all adjustment measures and some of the RCOPE subscales.

Greater levels of Stress-Related Growth were related significantly to greater use of all religious coping methods except Passive Religious Deferral and Punishing God Reappraisal. Better Religious Outcomes were associated significantly with greater use of all positive religious coping scales, as well as the Demonic Reappraisal, Passive Religious Deferral, and Pleading for Direct Intercessions subscales.

Poor Physical Health was correlated significantly with greater use of Pleading for Direct Intercession, Punishing God Reappraisal, Spiritual Discontent, and Reappraisal of God's Powers. Poor Physical Health also was related significantly to lower levels of Collaborative Religious Coping. Higher scores on the GHQ, indicating poorer mental health, were related significantly to higher scores for the Reappraisal of God's Powers, Spiritual Discontent, and Punishing God Reappraisal subscales, and to lower scores for the Seeking Support from Clergy or Members, Religious Focus, and Religious Helping subscales.

Greater emotional distress experienced at the time of the event was correlated significantly with greater use of Pleading for Direct Intercession and Reappraisal of God's Powers, and with less use of Passive Religious Deferral. Higher current-distress levels were related significantly to higher scores on the Spiritual Discontent, Pleading for Direct Intercession, Punishing God Reappraisal, Reappraisal of God's Powers, and Interpersonal Religious Discontent subscales.

Hospital Sample

The factor structure generated for the college sample was applied to the data from the hospital sample. It is important to remember, however, that a shorter version of the RCOPE was used in the hospital sample. Because the Spiritual Connection factor from the college sample contained only one item that was available in the hospital data, only 16 factors were examined in the hospital sample.

Table 5
Correlations between RCOPE Subscales and Adjustment Measures—College Sample

	Stress-Related Growth	Relig. Outcome	Phys. Health	GHQ	Distress at Time of Event	Distress Now
Negative Religious Coping Scales						
Spiritual Discontent	.14**	.02	−.14**	.11**	.04	.16**
Demonic Reappraisal	.12**	.20**	−.02	.01	−.07	.01
Passive Relig. Deferral	.04	.31**	−.05	.02	−.14**	.02
Interpersonal Religious Discontent	.10*	.01	−.08	.05	−.08	.10*
Reappraisal of God's Powers	.17**	.00	−.14**	.08*	.12**	.16**
Punishing God Reappraisal	.08	.01	−.17**	.17**	.07	.19**
Pleading for Direct Intercession	.31**	.38**	−.18**	.06	.14**	.20**
Positive Religious Coping Scales						
Purification/Forgive	.41**	.61**	−.06	−.07	.03	.04
Direction/Conversion	.37**	.50**	−.08	.00	.01	.08
Religious Helping	.32**	.57**	−.03	−.10*	.06	.04
Seeking Support: Clergy/Members	.23**	.57**	−.02	−.14**	.01	−.03
Collaborative Coping	.25**	.61**	.09*	−.07	.02	.00
Religious Focus	.28**	.63**	.01	−.13**	−.02	.02
Religious Surrender	.22**	.51**	.00	−.04	−.03	.00
Benevolent Reapp.	.32**	.70**	.03	−.08	.04	.01
Spiritual Connection	.34**	.65**	−.02	−.08	.04	.06
Marking Religious Boundaries	.15**	.47**	.04	−.04	−.05	−.04

*$p < .05$; **$p < .01$.

Table 6
t-tests Comparing Means for RCOPE Subscales from College and Hospital Samples

	College Sample	Hospital Sample	*t*
Negative Religious Coping Scales			
Spiritual Discontent	.51	.21	8.51**
Demonic Reappraisal	.25	.85	−12.05**
Passive Religious Deferral	.41	.69	−6.12**
Interpersonal Religious Discontent	.30	.38	−2.46*
Reappraisal of God's Powers	1.04	.49	11.18**
Punishing God Reappraisal	.51	.50	.10
Pleading for Direct Intercession	1.30	1.64	−5.69**
Positive Religious Coping Scales			
Religious Purification/Forgiveness	1.18	2.21	−19.69**
Religious Direction/Conversion	.69	1.54	−15.77**
Religious Helping	1.21	2.11	−16.81**
Seeking Support from Clergy or Members	.79	2.01	−21.67**
Collaborative Religious Coping	1.79	2.42	−14.18**
Religious Focus	.95	1.81	−15.30**
Active Religious Surrender	1.02	2.43	−25.69**
Benevolent Religious Reappraisal	1.54	2.14	−11.95**
Marking Religious Boundaries	.69	1.20	−13.10**

*$p < .01$; **$p < .001$.

Descriptive Statistics. As with the college sample, means were generally higher for the positive religious coping factors than for the negative factors (see Table 6). The highest means were found for the Active Religious Surrender ($M = 2.43$, *S.D.* = .94) and Collaborative Religious Coping subscales ($M = 2.42$, *S.D.* = .72). The lowest means were found for the Spiritual Discontent ($M = .21$, *S.D.* = .47) and Interpersonal Religious Discontent subscales ($M = .38$, *S.D.* = .60).

Comparison of College and Hospital Samples. Independent samples *t*-tests were conducted to determine if the means for the RCOPE factors differed across the two samples. For comparison purposes, 3-item versions of the RCOPE subscales were created for the college sample corresponding to the shorter version used in the hospital sample. Because of the large number of *t*-tests conducted, a correction for multiple tests was used. Given the 16 comparisons, results of the *t*-tests were required to be significant at an alpha level of .003 to be considered meaningful. However, an alpha level of .001 was applied here because it is a more conventionally used significance level and is slightly more conservative as well. These results are presented in Table 6.

Means for 14 of the 16 RCOPE subscales were significantly different across the two samples. As predicted, in general, the means for the religious coping subscales were significantly higher in the hospital sample than in the college sample. The hospital sample reported significantly greater use of 12 of the 16 religious coping factors. However, there was a tendency for the college sample to report significantly greater use of some of the more negative aspects of religious coping. The means for the college sample were significantly greater than for the hospital sample for the scales measuring Spiritual Discontent and Reappraisal of God's Powers. The only scales for which the means of the two

samples did not differ significantly were Punishing God Reappraisal and Interpersonal Religious Discontent.

Internal Consistency Results. Results indicate that the shorter RCOPE subscales also had generally acceptable internal consistency in the hospital sample. All but three subscales (Reappraisal of God's Power, Marking Religious Boundaries, and Interpersonal Religious Discontent) had alphas of .65 or greater, and seven subscales had alphas of .80 or greater. Those subscales with poor internal consistency were generally scales assessing negative aspects of religious coping that had very low means and little variance.

Confirmatory Factor Analysis. An attempt was made to confirm the factor structure from the college-student sample using the data from the hospital patients. It is important to confirm factor solutions on independent samples to ensure that results are not capitalizing on sample-specific characteristics. Because the two samples in this study are quite different demographically, religiously, and situationally, these data provided a particularly strong test of the generalizability of the factor structure. However, it is important to note that generalizability was limited by the use of the shorter versions of the scales in the hospital sample.

The confirmatory factor analysis (CFA) was conducted using LISREL VII (Joreskog & Sorbom, 1989). The results of the exploratory analysis were used to determine the factor structure for the CFA; of course, only those items in the shorter version of the scale were included in the CFA. The solution was constrained so that each item could load only on one factor. LISREL was unable to generate a solution using the complete college-student-factor structure. However, deleting two of the factors (Marking Religious Boundaries and Collaborative Religious Coping) allowed LISREL to generate a reasonable solution.

A CFA then was conducted using the remaining 51 items (see Table 2). The results are moderately supportive of the factor structure derived in the first sample. The CFA model with 14 of the 16 factors yielded a solution with an acceptable fit ($\chi^2 = 2406.46$, df = 1133, $p < .05$). When fitting a model, a chi-square value should typically be nonsignificant; however, chi-square values are very sensitive to large samples and tend to yield significant results even when the model fits the data well. Thus, two other indices of model fit that are less affected by sample size were used, and both suggested a good fitting model. First, a chi-square to degrees of freedom ratio of 2.12 was obtained. Values of this ratio that are less than 3.0 indicate a good fit of the model. Second, the root mean square error of approximation (RMSEA; Browne & Cudeck, 1992) was calculated. RMSEA values exceeding .10 are considered unacceptable, while values of .05 or less indicate a good fitting model. RMSEA for this solution was .046. Factor loadings from the CFA are presented in Table 2.

Cronbach alpha statistics were calculated for the RCOPE subscales based on the 14-factor solution. Alpha levels were acceptable (>.75) for the subscales, with the exceptions of Passive Religious Deferral ($\alpha = .66$) and Reappraisal of God's Powers, which contained only two items.

Discussion

The purpose of the present study was to develop and validate initially a comprehensive measure of religious coping. The results are encouraging in several ways. Factor analysis of the RCOPE items within the college-student sample yielded factors largely consistent with the conceptualization and construction of the subscales. In those instances in which

two subscales merged to form a factor, the combinations made intuitive sense. For example, there is a close connection between seeking forgiveness from God for one's own sins (Religious Purification) and seeking God's help to forgive others for their sins (Religious Forgiveness). Similarly, both Religious Conversion and Seeking Religious Direction are methods designed to create a major transformation in life. Furthermore, the 17 subscales of the RCOPE were consistent internally, with the exception of a few of the subscales that were skewed.

Second, the RCOPE was tied to a wide range of adjustment indices. Consistent with the findings in the general coping literature, two of the measures of adjustment more proximal to the stressful event (i.e., religious outcome, stress-related growth) were more strongly linked to the RCOPE subscales than the more distal adjustment measures (i.e., GHQ, physical health). Considering the fact that we are examining the ties between one stressor faced by an individual and his/her general physical- and mental-health status, to find statistically significant relationships between religious coping and the more distal measures is noteworthy. We would expect stronger relationships between religious coping and health status when coping is aggregated across the larger number of life stressors people experience over time. It also is important to note that although the RCOPE is a self-report measure, it was associated with not only other self-report measures, but also with several objective and salient indices, such as observer-rated cooperativeness and a number of medical diagnoses in the hospital sample (Koenig et al., 1998). Thus, the findings cannot be explained fully by a monomethod, self-report bias. Coupled with other investigations, these results indicate that religious coping has significant implications for a broad spectrum of attitudes, emotions, and behaviors.

Third, the RCOPE demonstrated evidence of incremental validity. Significant relationships between the RCOPE subscales and the measures of adjustment remained after controlling for the effects of gender and global religious measures. Therefore, the connection between religious coping and adjustment could not be explained by potentially confounding variables. Nor could the results simply reflect global differences in the religiousness of the participants. In fact, the RCOPE was by far the better predictor of adjustment to life stress, a finding that underscores the importance of moving beyond global religious indicators in stress and coping research to more detailed assessments of religious life. Finally, the results could not be explained by differences in the individual's generic approach to coping. In the hospital sample, Koenig et al. (in press) found that both religious and nonreligious coping measures added unique variance to the prediction of adjustment. This finding points to the need for greater attention to religion within the general coping literature; measures of coping that fail to attend to religiousness are missing an important dimension.

Fourth, the RCOPE proved to be applicable to populations with different levels of religiousness, with different problems, and at different ends of the adult life span. Given the diversity of the two samples, the ability to confirm l4 of the RCOPE factors within the hospital sample and the strengths of the relationships between the RCOPE and the measures of adjustment within both samples are noteworthy (Koenig et al., in press). With small adjustments in the directions and phrasing of some items, the RCOPE could be a useful tool for a variety of adult populations confronting many types of major life stressors.

Finally, the findings gleaned from the RCOPE subscales were interpretable. Because the subscales are detailed and comprehensive, it is possible to pinpoint specific dimensions of religiousness with the most important implications for adjustment. In addition, because the scales are functionally relevant and theoretically based, it is easier to make sense of the results than is the case with other measures of religious coping. Consider two examples. First, within the college-student sample, poorer physical and mental health

were associated with Punishing God Reappraisals, Reappraisals of God's Power, and Spiritual Discontent. These religious coping methods reflect attempts to redress a shaken sense of religious meaning and spirituality; they may hold negative implications for the health of these students. Second, within both college and hospitalized samples, stress-related growth and better religious outcomes were tied to each of the positive methods of religious coping. There may be, according to these results, many functional paths to personal and spiritual growth.

It is interesting to note that, even though the participants in both samples made less use of many of the negative religious coping methods (e.g., Interpersonal Religious Discontent, Demonic Reappraisal, Spiritual Discontent) than the positive ones (e.g., Seeking Spiritual Support, Benevolent Religious Reappraisal), the negative religious coping subscales still were predictive of adjustment, albeit in the negative direction. This finding underscores the importance of assessing potentially harmful, as well as potentially helpful, sides of religious life. Items from the negative religious coping subscales could serve as "red flags" to counselors, calling attention to the need for further assessment and discussion of religious issues in the counseling process (see also Pargament, Zinnbauer et al., 1998).

Limitations and Implications

Several limitations and remaining questions deserve some discussion. First, the results of the present analyses are cross-sectional and therefore do not permit causal inferences. While the methods of religious coping may have affected adjustment, it also is possible that different levels of adjustment elicited different forms and levels of religious coping. For example, higher levels of physical or mental distress conceivably could trigger higher levels of negative religious coping, such as Punishing God Reappraisal and Spiritual Discontent. Even if we were to assume that religious coping impacted on adjustment, questions remain about the longer-term implications of these religious coping methods. Are expressions of anger to God, for instance, short-lived phenomena associated with only momentary distress? Or do they have more long-lasting effects? If the effects are longer lasting, are they necessarily harmful? For some, expressions of religious anger and doubt may lead to meaningful and beneficial change (just recall the story of Job from the Bible). Measures of religious coping have been associated with changes in physical health and mental health over time in some studies (e.g., Harris et al., 1995, Koenig et al., 1992; Oxman et al., 1995; Pargament et al., 1994). Nevertheless, cross-sectional studies must be supplemented by longitudinal research if we are to sort out the extent to which distress mobilizes religious coping and religious coping reduces (or exacerbates) distress. More generally, longitudinal studies are needed to establish the predictive validity of the RCOPE.

It also is important to consider whether methods of religious coping work in similar ways for different people faced with different life stressors. As predicted, older people confronted with a serious medical illness generally made more use of religious coping methods than younger college students dealing with a wider range of problems. Other studies also have found differences in levels of religious coping as a function of social, personal, and situational factors (see Pargament, 1997 for a review). Less clear is whether methods of religious coping are equally helpful across groups and situations. As with other forms of coping, the value of any particular method may depend upon a complex interplay of factors. For example, Active Religious Surrender or Passive Religious Deferral may be particularly valuable to people confronting uncontrollable situations. Religious Purification may be especially helpful to individuals plagued by guilt. A few empirical studies have begun to suggest that the value of religious coping methods indeed may depend on variables, such as religious denomination (Tix & Frazier, 1998), health status

(Zuckerman et al., 1984), level of religiousness (Lasker, Lohmann, & Toedter, 1989), and the severity and controllability of the stressor (e.g., Bickel et al., 1998; Maton, 1989). Finer-grained analyses of different groups of people dealing with different stressors through different methods of religious coping are needed to build a more coherent body of knowledge in this area.

This type of "micro-analysis" of religious coping could set the stage for interventions that are more sensitive to religious and spiritual dimensions. Psychotherapists already have begun to apply a variety of religious coping methods to their work, with promising results. These include the use of forgiveness (Freedman & Enright, 1996; McCullough & Worthington, 1994), religious purification (Miller, 1988), religious reappraisals (Propst, l988), and spiritual support (Pargament, 1997). Research with the RCOPE may point to other valuable "psychospiritual" interventions, and the instrument itself may assist in the evaluation of these new methods of treatment.

This comprehensive measure of religious coping does have a major drawback for researchers and counselors—namely, its length. However, researchers interested in studying the role of religion in coping with specific life stressors could choose RCOPE subscales that theoretically are tied to their subject of interest. For example, the religious methods of coping that serve a meaning function might be selected for a study of victims of senseless crime. Religious methods of coping to gain comfort and closeness to God might be particularly relevant to studies of grief and bereavement. Survey researchers also might be interested in a brief form of the RCOPE that could help in statistical model testing of the relationships between religious coping and adjustment (see Koenig, 1997). We recently have developed a Brief RCOPE, one involving the identification of positive and negative patterns or clusters of religious methods of coping (Pargament, Smith, Koenig, & Perez, 1998). A brief measure of religious coping, however, will not substitute for the complete RCOPE.

The RCOPE was designed to provide something long overdue—a detailed, comprehensive assessment of religious coping for researchers and practitioners. Of course, the RCOPE will not fit into a standard assessment battery in counseling, for reasons of not only length, but content as well. After all, religious issues are not salient to all clients. Many clients, however, are religious or spiritually oriented (see Shafranske, 1996). For them, religion may represent a potent resource for coping or a source of problems in itself. Comprehensive assessment of religious coping in these cases would be very appropriate, even essential to the counseling process. Hopefully, the RCOPE will contribute to a richer understanding of the many expressions of religion in coping and to a more complete integration of religious and spiritual dimensions into the process of counseling.

References

American Association of Anesthesiologists. (1963). New classification of physical status. Anesthesiology, 24, 191–198.

Bahr, H.M., & Harvey, C.D. (1979). Correlates of loneliness among widows bereaved in a mining disaster. Psychological Reports, 44, 367–385.

Bergin, A.E., Masters, K.S., & Richards, P.S. (1987). Religiousness and mental health reconsidered: A study of an intrinsically religious sample. Journal of Counseling Psychology, 35, 197–204.

Bickel, C., Ciarrocchi, J.W., Sheers, N.J., Estadt, B.K., Powell, D.A., & Pargament, K.I. (1998). Perceived stress, religious coping styles, and depressive affect. Journal of Psychology and Christianity, 17, 33–42.

Boudreaux, E., Catz, S., Ryan, L., Amaral-Melendez, M., & Brantley, P.J. (1995). The ways of religious coping scale: Reliability, validity, and scale development. Assessment, 2, 233–244.

Browne, M., & Cudeck, R. (1992). Alternative ways of assessing model fit. Sociological Methods and Research, 21, 230–258.

Buber, M. (1970). I and Thou. New York: Charles Scribner's Sons.

Bulman, R.J., & Wortman, C.B. (1977). Attributions of blame and coping in the "real world": Severe accident victims react to their lot. Journal of Personality and Social Psychology, 35, 351–363.

Carver, C.S., Scheier, M.F., & Weintraub, J.K. (1989). Assessing coping strategies: A theoretically-based approach. Journal of Personality and Social Psychology, 56, 267–283.

Conway, K. (1985–1986). Coping with the stress of medical problems among black and white elderly. International Journal of Aging and Human Development, 21, 39–48.

Durkheim, E. (1915). The elementary forms of religious life. New York: Free Press.

Ellison, C.G., & Taylor, R.J. (1996). Turning to prayer: Social and situational antecedents of religious coping among African Americans. Review of Religious Research, 38, 111–131.

Ferraro, K.F., & Koch, J.R. (1994). Religion and health among black and white adults: Examining social support and consolation. Journal for the Scientific Study of Religion, 33, 362–375.

Folkman, S., Lazarus, R.S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R.J. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. Journal of Personality and Social Psychology, 50, 992–1003.

Freedman, S.R., & Enright, R.D. (1996). Forgiveness as an intervention goal with incest survivors. Journal of Consulting and Clinical Psychology, 64, 983–992.

Freud, S. (1961). The future of an illusion. New York: Norton. (Original work published 1927)

Fromm, E. (1950). Psychoanalysis and religion. New Haven: Yale University Press.

Geertz, C. (1966). Religion as a cultural system. In M. Banton (Ed.), Anthropological approaches to the study of religion (pp. 1–46). London: Tavistock.

Goldberg, D. (1978). Manual of the General Health Questionnaire. Windsor: National Foundation for Educational Research.

Gorsuch, R.L. (1984). Measurement: The boon and bane of investigating religion. American Psychologist, 39, 228–236.

Gurin, G., Veroff, J., & Feld, S. (1960). Americans view their mental health: A nationwide interview survey. New York: Basic Books.

Harris, R.C., Dew, M.A., Lee, A., Amaya, M., Buches, L., Reetz, D., & Coleman, G. (1995). The role of religion in heart transplant recipients' long-term health and well-being. Journal of Religion and Health, 34, 17–32.

Hood, R.W., Jr., Spilka, B., Hunsberger, B., & Gorsuch, R. (1996). The psychology of religion: An empirical approach (2nd ed.). New York: Guilford Press.

ICD-9 (1989). The international classification of diseases (9th rev., 3rd ed., Vol. 1). DHHS Pub. No. (PHS) 89–1260. Hyattsville, MD: DHHS.

Johnson, P.E. (1959). Psychology of religion. Nashville: Abingdon Press.

Joreskog, K., & Sorbom, D. (1989). LISREL 7: User's reference guide. Mooresville, IN: Scientific Software.

Keefe, F.J. (1992). The coping strategies questionnaire. Unpublished manuscript, Duke University Medical Center, Pain Management Program, Durham, NC.

Koenig, H.G. (1997). Is religion good for your health? The effects of religion on physical and mental health. Binghamton, New York: Haworth Press.

Koenig, H.G., Cohen, J.J., Blazer, D.G., Kudler, H.S., Krishnan, K.R.R., & Sibert, T.E. (1995). Religious coping and cognitive symptoms of depression in elderly medical patients. Psychosomatics, 36, 369–375.

Koenig, H.G., Cohen, H.J., Blazer, F.H., Pieper, C., Meador, K.G., Shelp, F., Goli, V., & DiPasquale, B. (1992). Religious coping and depression among elderly, hospitalized medically ill men. American Journal of Psychiatry, 14, 1693–1700.

Koenig, H.G., Pargament, K.I., & Nielsen, J. (1998). Religious coping and health outcomes in medically ill hospitalized older adults. Journal of Nervous and Mental Diseases, 186, 513–521.

Lasker, J.N., Lohmann, J., & Toedter, L. (1989, November). The role of religion in bereavement: The case of pregnancy loss. Paper presented at the meeting of the Society for the Scientific Study of Religion, Salt Lake City, UT.

Lazarus, R.S., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

Lovinger, R. (1984). Working with religious issues in psychotherapy. New York: Aronson.

Mattlin, J.A., Wethington, E., & Kessler, R.C. (1990). Situational determinants of coping and coping effectiveness. Journal of Health and Social Behavior, 31, 103–122.

McCubbin, H.I., Dahl, B.B., Lester, G.R., Benson, D., & Robertson, M.L. (1976). Coping repertoire of families adapting to prolonged war-induced separations. Journal of Marriage and the Family, August, 461–471.

McCullough, M.E., & Worthington, E.L., Jr. (1994). Encouraging clients to forgive people who have hurt them: Review, critique, and research prospectus. Journal of Psychology and Theology, 22, 3–20.

McIntosh, D.N., & Spilka, B. (1990). Religion and physical health: The role of personal faith and control. In M.L. Lynn & D.O. Moberg (Eds.), Research in the social scientific study of religion (Vol. 2, pp. 167–194). Greenwich, CT: JAI Press.

Maton, K.I. (1989). The stress-buffering role of spiritual support. Journal for the Scientific Study of Religion, 28, 310–323.

Miller, W.R. (1988). Including clients' spiritual perspectives in cognitive-behavioral therapy. In W.R. Miller & J.E. Martin (Eds.), Behavior therapy and religion: Integrating spiritual and behavioral approaches to change (pp. 43–55). Newbury Park: Sage.

Moos, R.H., Cronkite, R.C., Billings, A.G., & Finney, J.W. (1986). Health and daily living manual—revised version. Palo Alto, CA: Veterans Administration and Stanford University Medical Centers.

Oxman, T.E., Freeman, D.H., Jr., & Manheimer, E.D. (1995). Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. Psychosomatic Medicine, 57, 5–15.

Pargament, K.I. (1997). The psychology of religion and coping: Theory, research, practice. New York: Guilford Press.

Pargament, K.I., Ensing, D.S., Falgout, K., Olsen, H., Reilly, B., Van Haitsma, K., & Warren, R. (1990). God help me (I): Religious coping efforts as predictors of the outcomes to significant negative life events. American Journal of Community Psychology, 18, 793–824.

Pargament, K.I., Ishler, K., Dubow, E., Stanik, P., Rouiller, R., Crowe, P., Cullman, E., Albert, M., & Royster, B.J. (1994). Methods of religious coping with the Gulf War: Cross-sectional and longitudinal analyses. Journal for the Scientific Study of Religion, 33, 347–361.

Pargament, K.I., Kennell, J., Hathaway, W., Grevengoed, N., Newman, J., & Jones, W. (1988). Religion and the problem-solving process: Three styles of coping. Journal for the Scientific Study of Religion, 27, 90–104.

Pargament, K.I., & Park, C.L. (1995). Merely a defense? The variety of religious means and ends. Journal of Social Issues, 5, 13–32.

Pargament, K.I., Smith, B., Koenig, H.G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. Journal for the Scientific Study of Religion, 37, 710–724.

Pargament, K.I., Zinnbauer, B.J., Scott, A.B., Butter, E.M., Zerowin, J., & Stanik, P. (1998). Red flags and religious coping: Identifying some religious warning signs among people in crisis. Journal of Clinical Psychology, 54, 77–89.

Park, C.L., & Cohen, L.H. (1993). Religious and nonreligious coping with the death of a friend. Cognitive Therapy and Research, 17, 561–577.

Park, C.L., Cohen, L.H., & Murch, R.L. (1996). Assessment and prediction of stress-related growth. Journal of Personality, 64, 71–105.

Pressman, P., Lyons, J.S., Larson, D.B., & Strain, J.J. (1990). Religious belief, depression, and ambulation status in elderly women with broken hips. American Journal of Psychiatry, 147, 758–760.

Propst, L.R. (1988). Psychotherapy in a religious framework: Spirituality in the emotional healing process. New York: Human Services Press.

Richards, P.S., & Bergin, A.E. (1997). A spiritual strategy for counseling and psychotherapy. Washington, DC: APA Books.

Schumaker, J.F. (Ed.). (1992). Religion and mental health. New York: Oxford University Press.

Shafranske, E.P. (Ed.). (1996). Religion and the clinical practice of psychology. Washington, DC: APA.

Sherkat, D.E., & Reed, M.D. (1992). The effects of religion and social support on self-esteem and depression among the suddenly bereaved. Social Indicators Research, 26, 259–275.

Tix, A.P., & Frazier, P.A. (1998). The use of religious coping during stressful life events: Main effects, moderation, and mediation. Journal of Consulting and Clinical Psychology, 66, 411–422.

Worthington, E.L., Jr. (1989). Religious faith across the lifespan: Implications for counseling and research. Counseling Psychologist, 17, 555–612.

Zinnbauer, B., Pargament, K.I., & Scott, A. (in press). Emerging meanings of religiousness and spirituality: Problems and prospects. Journal of Personality.

Zuckerman, D.M., Kasl, S.V., & Ostfeld, A.M. (1984). Psychosocial predictors of mortality among the elderly poor. American Journal of Epidemiology, 119, 410–423.