Life Stress, Coping, Perceived Health, and Health Outcomes Among Eastern Orthodox Clergy

{Student Name}

Doctor of Philosophy – Health Psychology
Problem Statement

According to Wells (2013), determining the association between stress, coping, and health perceptions is important in predicting actual health outcomes. Health outcomes, such as chronic diseases (e.g., cardiovascular disease, obesity, diabetes, cancer, etc.) influence physical and emotional functioning in clerical populations (Doolittle, 2007). According to Proeschold-Bell and LeGrand (2012), clergy exhibit higher stress and mortality rates in relation to their non-clergy counterparts. Despite current research on clergy stress and mortality rates, health perceptions and health outcomes of Western religious-oriented clergy have been under-studied (Proeschold-Bell & LeGrand, 2012). Even less is known about health perceptions and health outcomes of Eastern religious-oriented clergy (Trevino & McConell, 2014).

The association between stress, coping, and health is significant in clerical populations because of the impact it might have on serving their parishioners. Wells (2013) indicated that clergy who have been in the ministry for an extended time-period, exhibit coping styles that yield greater positive actual health outcomes in relation to their younger clergy counterparts. Therefore, it would be beneficial to assess the coping styles clergy possess that influence their actual health outcomes.

Although data have been collected in relation to clergy health outcomes, little is known about the impact that specific coping styles have on health perceptions and actual health outcomes (Proeschold-Bell & LeGrand, 2012). Proeschold-Bell and LeGrand
(2012) found higher than average rates of obesity, diabetes, and blood pressure in clergy compared to non-clergy. Cutts, Gunderson, Proeschold-Bell and Swift (2012) found that clergy exhibit higher chronic disease rates, including cardiovascular issues, diabetes, and obesity, than their non-clergy counterparts, with decreased perceived health issue awareness. Masters and Knestel’s (2011) study found that positive religious coping is associated with healthier blood pressure levels.

There is a discrepancy between clerical health perceptions and actual health outcomes (Preschold-Bell & LeGrand, 2012). Clergy exhibit favorable health perceptions that are inconsistent with their actual health outcomes. Increased understanding of the discrepancy between high clergy disease rates and health perceptions is needed (Proeschold-Bell & LeGrand, 2012). Doolittle (2007) found that problem-focused coping styles, including acceptance, active coping, planning, and positive reframing, enhance clergy daily function and overall health outcomes, including health conditions (e.g., chronic disease). However, emotion-focused and avoidant-oriented coping styles such as denial, substance use, humor, and religious coping, have been understudied (Doolittle, 2007). Therefore, further assessment of these understudied coping styles (i.e., emotion-focused and avoidant-oriented coping) is needed in order to better understand the association between stress, coping, and actual clergy health outcomes, including health conditions (chronic disease).

**Purpose**

In a society where health outcomes significantly influence daily function, it is important to understand the relationships between the stressors of life, ways of coping, and perceptions of health. There is limited research on the relationship between life
stress, coping, health perceptions, and actual health outcomes among Eastern Orthodox clergy (Doolittle, 2007; Proeschold-Bell & LeGrand, 2012; Wells, 2013). The purpose of this study is to address a gap in the literature by examining whether stress, coping (problem-focused, emotion-focused, avoidant-oriented), and health perceptions (perception of mental and physical health status) predict actual health outcomes (chronic diseases such as cardiovascular disease, diabetes, obesity, etc.). To address this gap, a quantitative assessment of the relationship between life stress, coping styles, perceived health, and actual health outcomes will be conducted. With the results of this study, I hope to provide insights into the relationship between stress, coping styles, health perceptions, and actual health outcomes in Eastern Orthodox clergy residing in the United States using the self-regulation framework in determining which aspects of stress, coping, religious coping (positive and negative), and health perceptions predict health outcomes.

**Significance**

This study will address a gap in the literature by examining which factors of stress, coping, and health perceptions predict actual health outcomes (chronic disease). This study is unique in that it attempts to research an area of life stress that has not been studied in the manner of the present study. That is, this study will examine whether these variables (life stress, coping styles, and health perceptions) predict chronic health conditions. This study is important because in a society in which chronic disease is so prevalent in the clerical population, the results of this study could help me shed light on which factors of stress, coping, and health perceptions may lead to chronic disease. If we are able to understand which factors of life stress, coping, and health perceptions most
predict health outcomes, this study may have implications for further research on how we may manipulate those factors to promote clergy health.

With the results of this research study, I hope to have the potential to create positive social change. From these research findings, I hope to identify specific life stressors, coping styles, and health perceptions that may be related to unexpected health implications, leading to chronic health conditions. If it is determined that life stress, coping styles, and health perceptions lead to health conditions, it could mean that the health of our clergy is being jeopardized, which has implications for all parishioners. Clergy have lower actual health outcomes than non-clergy counterparts and suffer from optimistic views on health perceptions (Proeschold-Bell & LeGrand, 2012). Thus, addressing the relationship between life stress, coping styles, health perceptions, and health conditions may lead to increased well-being among clergy. Understanding the possible disconnect between health perceptions and actual health outcomes, can also lead to healthier behaviors, increased clergy function, and decreased clergy health costs.

**Background**

Selected articles relating to life stress, coping styles, health perceptions, and health outcomes are described here:

1. Wells (2013) provided information on clergy age and time in ministry, which have been shown to be key predictors of health status outcomes, such as older clergy who have been in the ministry longer exhibit more positive actual health outcomes in relation to their younger clergy counterparts.

2. Trevino and McConnell (2014) provided information on the positive relationship between religious coping and physical health and indicated that further research
must be conducted in order to identify gaps in the literature regarding the relationship between these two variables.


4. Masters and Knestel (2011) provided information on the positive association between religious coping and health outcomes, indicating that higher religious coping yields better health outcomes.

5. Cutts, Gunderson, Proschold-Bell, and Swift (2012) provided information on clergy health perceptions and actual health outcomes, indicating a disconnect between the two variables. This disconnect involves over or underestimation of health perceptions on actual health outcomes.

6. Proeschold-Bell and LeGrand (2012) found that clergy have lower actual health outcomes than non-clergy counterparts and suffer from optimistic views on health perceptions.

**Framework**

The literature on religious coping and health has increased but suffers from a lack of integrative theoretical models (Aldwin, Park, Jeong, & Nath, 2014). According to de Ridder and de Wit (2006) health behaviors are subject to self-regulation because they involve the person as an active agent and draw on volitional processes of goal striving. For instance, are clergy really self-regulating (choosing their own goals) or are they being regulated (following religious orders) when deciding to engage in healthier behaviors? Therefore, it would be beneficial to consider this framework in assessing clergy adopted
health perceptions that direct their behavior and actual health outcomes (de Ridder & de Wit, 2006). Consequently, application of the self-regulation theory aligns well with the goal of this research study in better understanding the relationship between coping styles, health perceptions, and actual health outcomes among clergy (de Ridder & de Wit, 2006). Tougas, Hayden, McGrath, Huguet, and Rozario (2015) explored a self-regulation framework for chronic health condition interventions and health outcomes. Consistent use of self-monitoring, self-judgment, and self-evaluation were found to be predictors of lower rates of health conditions. Based on Tougas et al.’s (2015) meta-analysis, self-regulation theory is commonly applied to study development of chronic health conditions and symptoms, as well as intervention effectiveness.

Booker and Mullan (2013) used self-regulation to examine the influences of environmental cues and life stress on health outcomes. Specifically, self-regulation influences healthy lifestyle maintenance. Participants who perceived environmental support, including social, communal, and intrapersonal networking, during stressful life events were significantly more likely to maintain a healthy lifestyle and better actual health outcomes. Given how coping styles may be influenced by one’s environment, it would be beneficial to understand these perceptions among clergy using the self-regulation framework. Understanding the influences of coping styles and health perceptions on actual health outcomes through the self-regulation theory opens the door to many new research directions, including behavioral, emotional, and cognitive regulation among clergy and other populations of study.

**Research Questions**
The purpose of this study is to examine the relationship between life stress, coping styles (problem-focused, emotion-focused, and avoidant-oriented), religious coping (negative and positive), health perceptions (mental component summary scores and physical component summary scores) and actual health outcomes (chronic diseases) in eastern orthodox clergy.

This study will address the following research questions:

1. RQ1 – Quantitative: Is life stress, as measured by the Social Readjustment Rating Scale, related to actual health outcomes (chronic conditions such as cardiovascular disease, obesity, cancer, and diabetes), as measured by the Chronic Health Problems Checklist, in Eastern Orthodox clergy?

   **Null Hypothesis #1.** Life stress is not a significant predictor of actual health outcomes (chronic disease).

   **Alternate Hypothesis #1.** Life stress is a significant predictor of actual health outcomes (chronic disease).

2. RQ2 – Quantitative: Is coping style (problem-focused, emotion-focused, and avoidant-oriented), as measured by the Brief COPE Inventory related to actual health outcomes (chronic conditions such as cardiovascular disease, obesity, cancer, and diabetes), as measured by the Chronic Health Problems Checklist, in Eastern Orthodox clergy?

   **Null Hypothesis #1.** Coping style (problem-focused, emotion-focused, and avoidant-oriented) is not a significant predictor of actual health outcomes (chronic disease).
**Alternate Hypothesis #1.** Coping style (problem-focused, emotion-focused, and avoidant-oriented) is a significant predictor of actual health outcomes.

3. **RQ3 – Quantitative:** Is religious coping (negative and positive), as measured by the Brief Religious Coping Inventory, related to actual health outcomes (chronic conditions, such as cardiovascular disease, obesity, cancer, and diabetes), as measured by the Chronic Health Problems Checklist, in Eastern Orthodox clergy?

**Null Hypothesis #1.** Religious coping (positive and negative) is not a significant predictor of actual health outcomes (chronic disease).

**Alternate Hypothesis #1.** Religious coping (positive and negative) is a significant predictor of actual health outcomes (chronic disease).

4. **RQ4 – Quantitative:** Is health perception (mental health and physical health), as measured by the Short-Form Health Survey (SF-12), related to actual health outcomes (chronic conditions, such as cardiovascular disease, obesity, cancer, and diabetes), as measured by the Chronic Health Problems Checklist, in Eastern Orthodox clergy?

**Null Hypothesis #1.** Health perception (mental health and physical health) is not a significant predictor of actual health outcomes (chronic disease).

**Alternate Hypothesis #1.** Health perception (mental health and physical health) is a significant predictor of actual health outcomes (chronic disease).

5. **RQ5 – Quantitative:** Is chronological age, related to actual health outcomes (chronic conditions, such as cardiovascular disease, obesity, cancer, and diabetes), as measured by the Chronic Health Problems Checklist, in Eastern Orthodox clergy?
**Null Hypothesis #1.** Chronological age is not a significant predictor of actual health outcomes (chronic disease).

**Alternate Hypothesis #1.** Chronological age is a significant predictor of actual health outcomes (chronic disease).

6. **RQ6 – Quantitative:** Is time in ministry, related to actual health outcomes (chronic conditions, such as cardiovascular disease, obesity, cancer, and diabetes), as measured by the Chronic Health Problems Checklist, in Eastern Orthodox clergy?

**Null Hypothesis #1.** Time in ministry is not a significant predictor of actual health outcomes (chronic disease).

**Alternate Hypothesis #1.** Time in ministry is a significant predictor of actual health outcomes (chronic disease).

**Nature of the Study**

The nature of this study will be quantitative. Quantitative research is consistent in collecting numerical data using an objective, formal, and systematic process, in describing variables, examining relationships among variables and determining cause-and-effect interactions between variables (Creswell, 2014). This study will use a quantitative method approach to collect data on life stress, coping style and religious coping, health perceptions, and actual health outcomes. Holmes and Rahe’s (1967) Social Readjustment Rating Scale will be used to collect life stress data in a reliable and valid manner. Rahe, Biersner, Ryman, and Arthur (1972) found the Social Readjustment Rating scale to be reliable and valid in assessing the relationship between life stress and medical problems. This scale has been assessed against different populations within the United States and tested cross-culturally, comparing Japanese and Malaysian groups with

Pargament, Feuille, and Burdzy’s (2011) Brief Religious Coping was designed to measure positive and negative subscales of the 14-item scale. The Brief RCOPE has demonstrated good internal consistency in a number of studies across widely differing samples that included patients undergoing cardiac surgery, African American women with a history of partner violence, cancer patients, caregivers for cancer patients, a community sample of U.K. adults, older adults in residential care, outpatients with alcohol use disorders, HIV patients, Catholic middle school students, and a sample of residents in Massachusetts and New York City following 9/11.

Ware, Kosinski, and Keller (1996) developed a 12-Item Short-Form Health Survey (SF-12), to assess mental and physical health perceptions. Busija, Pausenberger, Haines, Haymes, Buchbinder, and Osborne (2011) used the SF-12 to measure functional health and well-being perspectives from general and clinical populations. Miles, Proescholdbell, and Puffer (2011) used the SF-12 to measure perceptions of mental and physical health in United Methodist clergy residing in the Southern US and found it to be a reliable and valid measurement tool. The perception of mental health is measured with the mental component summary score (subscale) and the perception of physical health is measured with the physical component summary score (subscale). Actual health
outcomes, including health conditions (chronic disease), will be collected using Barrett et al. (2002), Chronic Health Problems Checklist, developed in assessing physical health symptoms, such as chronic disease in various populations. The Chronic Health Problems Checklist was developed based on Beckham, Moore, Feldman, Hertzberg, Kirby, and Fairbank’s (1998) dichotomous rating checklist (0=no, 1=yes) and is now a self-report measure commonly used for collecting actual health outcomes (chronic health conditions) in diverse populations. Schry et al. (2015), also used the checklist to assess health conditions, including chronic disease, in U.S. veterans. Barrett et al. (2002) used checklist to assess health conditions, including chronic disease, such as cardiovascular disease, obesity, diabetes, and cancer in army veterans. According to Schry et al. (2015), using the checklist in collecting health conditions (chronic disease) is a common practice amongst all populations. Lastly, age and time in ministry will be collected using Wells’ (2013) self-report format.

**Possible Types and Sources of Data**

1. The Eastern Orthodox Clergy Database (Orthodox Church in America, 2016) will be used as a primary source in collecting clergy contact information prior to survey administration. Eastern Orthodox Clergy are composed of Greek, Russian, Bulgarian, Coptic, Romanian, Armenian, Antiochian, and Coptic Orthodox males, with a Masters of Divinity credential, whereas Western Orthodox Clergy are composed of Catholic, Protestant, Evangelical, and Methodist (Siecienski, 2010). Gender will not be a variable since all of the Eastern Orthodox clergy are composed of only males.
2. A mass email will be sent to all of the Eastern Orthodox clergy listed in the Eastern Orthodox Clergy Database to initially obtain study participation eligibility through predetermined screening questions. Eligibility criteria include: over the age of 18 years old, residing in the United States for over five years, and clerical profession for a minimum of 1 year.

3. Holmes and Rahe’s (1967) Social Readjustment Rating Scale will be administered through SurveyMonkey.com to measure life stress among eastern orthodox clergy. Scores between 0 and 150 indicate relatively low amount of life change and a low susceptibility to stress-induced health problems; scores between 150 – 300 indicate a 50% chance of a major stress-induced health problem in the next 2 years; and scores of 300 or more, raise the odds to about 80%.

4. Carver’s (1997) Brief COPE Inventory will be administered through SurveyMonkey.com to measure coping styles (problem focused, emotion focused, and avoidant-oriented) among eastern orthodox. Higher scores indicate greater use of the strategy.

5. Pargament, Feuille, and Burdzy’s (2011) Brief Religious Coping Inventory will be administered through SurveyMonkey.com to measure religious coping styles (positive versus negative). Positive and negative coping subscale items are included in the 14-item scale.

6. Ware, Kosinski, and Keller’s (1996) 12-Item Short-Form Health Survey (SF-12) will be administered through SurveyMonkey.com to measure health perceptions, among eastern orthodox clergy. The Mental Component
Summary Score (MSC) measures mental health perceptions and the Physical Component Summary Score (PCS) measures physical health perceptions.

7. Schry, Rissling, Gentes, Beckham, Kudler, Straits-Troster, and Calhoun’s (2015) self-report measure will be used to measure actual health outcomes (health conditions and symptoms, including cardiovascular disease, obesity, diabetes, and cancer) using dichotomous rating checklists.

8. Age and time in ministry will be collected using Wells’ (2013) self-report format.

Possible Analytic Strategies

This study will be conducted using quantitative survey research, investigating the relationship between life stress, coping styles, health perceptions, and actual health outcomes (health conditions and symptoms) in eastern orthodox clergy residing in the United States. The survey design will be cross-sectional with the data collected at one particular point in time using the Internet for survey administration.

Multiple regression analysis will be conducted to predict the value of the dependent variable based on the value of two or more independent variables (Green & Salkind, 2014). The independent variables used to predict actual health outcomes include the following: life stress, coping styles, religious coping, health perceptions, age, and time in ministry.
References


Busija, L., Pausenberger, E., Haines, T. P., Haymes, S., Buchbinder, R., & Osborne, R. H. (2011). Adult measures of general health and health-related quality of life: Medical Outcomes Study Short Form 36-Item (SF-36) and Short Form 12-Item (SF-12) Health Surveys, Nottingham Health Profile (NHP), Sickness Impact
Profile (SIP), Medical Outcomes Study Short Form 6D (SF-6D), Health Utilities Index Mark 3 (HUI3), Quality of Well-Being Scale (QWB), and Assessment of Quality of Life (AQOL). *Arthritis Care & Research,* 63(11), 383-412. doi: 10.1002/acr.20541


Orthodox Church in America. (2016). Retrieved from https://oca.org/directories


Pesut, D., Raskovi, S., Tomic-Spiric, V., Bulajic, M., Bogic, M., Bursuc, B., & Peric-


doi:10.1007/s10943-014-9897-0


doi:10.1177/002202217100200407