AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS OF RELIGIOUS COPING AND RELATIONSHIP WITH GOD AMONG OLDER ADULTS WITH FUNCTIONAL IMPAIRMENTS

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ABSTRACT

This study represents a qualitative exploration of several phenomena within religious coping. The aims of this study were threefold. First was to evaluate the nature of older adults’ relationship with God and their God-person interaction style. In addition, we sought to understand how control and acceptance were experienced in this context. Second, this study aimed to explore participants’ understanding of a standard measure of religious coping. Third, this study aimed to explore potential areas of divergence in the nature of study phenomena between African American and White participants. Guided by hermeneutic phenomenology, 25 interviews were conducted (13 African American, 12 White). Cognitive interviews evaluating understanding of a survey measure (RCOPE) of one’s relationship with God were conducted to qualitatively inform quantitative research with this oft-used measure and to explore racial/ethnic divergences within its factors.

Results of phenomenological analyses included a thorough description and interpretation of one’s relationship with God (themes included: intimacy with and presence of God), the use of one’s relationship with God when coping (themes: communication to and from God, reliance on God, God provides), and the experience of incorporating this relationship throughout the coping process (themes: My part, faith, God’s will, God’s time, relinquish, acceptance and control). Emergent themes were discussed within the framework of the motivational theory of lifespan development and the transactional theory of stress and coping. Participants’ coping represented both primary and secondary control processes as well as problem-, emotion-, and meaning-focused coping. One’s perception of God’s will and God’s time were interpreted as essential
elements with significant implications for one’s ability to accept one’s situation. African Americans reported a distinct intimacy with God defined by God’s enhanced knowledge of them.

Novel understanding of participants’ comprehension and response-formation processes of an RCOPE subscale were explored. The need for another factor was delineated through the exploration of participants’ construct-incongruent comprehension of the collaborative coping items. The factor would be less indicative of a relationship defined by equality. This factor was salient among African Americans. Furthermore, adding a factor assessing relinquishing prior to reaching one’s level of perceived restraints was indicated from the results.
LIST OF ABBREVIATIONS AND SYMBOLS

AF AM  African American
F  Fisher’s F ratio: A measurement of two variances
M  Mean: the sum of a set of measurements divided by the number of measurements in the set
N  Total number in a sample
p  Probability associated with the occurrence under the null hypothesis of a value as extreme as or more extreme than the observed value
r  Pearson product-moment correlation
SD  Standard deviation
t  Computed value of t test
<  Less than
=  Equal to
%  Percent
ACKNOWLEDGMENTS

At times, during pursuit of scientific advance, I feel as if the best that one can hope for is to sense the nip of visceral exhilaration as is unveiled – for its maiden voyage – a new, wispy tendril, uncovered from its hiding place amongst the shadows in the fog. The trudge that accompanies the work represented here through book and binding was not accomplished unattended. My cerebral peregrination is plodded with personage of note: Becky Allen, with sight of soothsayer and staff of shepherd and Daniel Durkin, with words of unwavering wisdom. The participants, who conduct the light with which the sea of novel understanding is illuminated, deserve sparks of praise for their brilliance. Without them, the shadows overwhelm and the fog is complete. Empirical expertise and intellectual insight of Allen, Durkin, and fellow committee steer true the vessel which floats on the waves of light flowing forth from participants; however, the journey is made on the wind of loved ones who bolster the sails and strengthen their tenacity. My wife, Kristie, is a gale to the canvas. Intrepid is the ship when receiving her presence. My daughter, Ripley, is a gentle warm breeze. Innocent grace presses forward the path and tenders the heart of the mast. Deep in the grain and gnarls of the deck made of wood lies the legacy of those trees which stood mighty in storms. To those trees who have fallen and to those with branches still for shade, I tip my hat for your presence and for what you have made.
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INTRODUCTION

Illnesses and disorders that older adults experience are vast in number and scope. These illnesses and disorders bring about functional limitations and disability. The massive volume of older adults that will have age-related illnesses in the coming years is daunting and necessitates the vigilance of the health and mental healthcare community.

The presence of an illness and the potential for concomitant functional disability and impairments bring multiple onerous alterations in the life of an older adult. These changes often result in stress and other negative emotions. Some changes in older adults may provide resources for coping with the disease state and functional impairments that sometimes affect people at this stage of life. For example, results of a national survey indicated that older adults reported a greater degree of religiosity than younger adults (Levin, Taylor, & Chatters, 1994; Taylor, Mattis, & Chatters, 1999). In addition, one’s sense of religiosity and spirituality has been found to increase as one transitions from middle adulthood to older adulthood (Idler, Kasl, & Hays, 2001; Wink & Dillon, 2002).

Religious Coping

A substantial proportion of people in stressful situations use religion to cope with their hardships (Pargament, 1997). Among older adults and minorities, religious coping is cited more frequently than any other form of coping (Koenig, 1998). In a review of religion and coping, Pargament (1997) indicated that religious coping is an important predictor of well-being. In addition, it has been suggested that measures of religious coping are stronger predictors of emotional outcomes of stressful situations than global measures of religiosity (e.g., prayer,
church attendance). Notably, a meta-analysis of the effect of religiosity on emotional health conducted by Hackney and Sanders (2003) reported that personal devotion (i.e., intrinsic religious orientation, relationship with God) displayed a higher relation to emotional health than institutional religion (i.e., church attendance, participation in church activities). Importantly, the associations of religious coping with indicators of well-being have been shown even when controlling global religious measures (Pargament, et al., 1999; Pargament, Koenig, Perez, 2000). A clearer picture of the relation of religion and spirituality with health and well-being is attained when the specific ways in which people utilize their religion and spirituality to cope with hardships (i.e., religious coping styles) are assessed.

There is substantial empirical evidence that the use of religious coping is related to positive physical and mental health outcomes among adults with health problems, a trend which may be particularly salient among older adults. Religious coping has been linked with decreased depression (Caplan, Sawyer, Holt, & Alman, 2013; Idler & Kasl, 1997; Pargament, Koenig, & Perez, 2000), decreased stress (Taylor, Chatter, & Levin, 2004; Krause, 2006), positive adjustment to cancer (Allmon, Tallman, & Altmaier, 2013; Gall & Cornblat, 2002; Gall, Miguez de Renart, & Boonstra, 2000; Krause, 1993; Meyer, Altmaier, & Burns, 1992), positive adjustment to HIV (Lee, Nezu, & Nezu, 2014) and decreased mortality (McCullough, Hoyt, Larson, Koenig, & Thoreson, 2000; Oxman, Freeman, & Manheimer, 1995; Pargament, Koenig, & Perez, 2000).

Delineating ways in which one uses religion and spirituality in relation to stress and health-related problems – defining religious and spiritual coping strategies – allows for a more specific assessment of the association between religion and spirituality and mental and physical health. One’s relationship with God or a Higher Power (to be truncated to “God” hereafter for
ease of reading) has frequently been discussed as a means of religious and spiritual coping. One’s relationship with God is often experienced as an essential aspect of coping (Casarez & Miles, 2008; Gall & Cornblat, 2002; Harris, Allen, Dunn, & Parmelee, 2013; McAuley, Pecchioni, & Grant, 2000). In addition, people who report having a relationship with God and relying on this relationship often report that they are provided with additional resources and supports, such as strength, hope, optimism, and a positive perspective (Bhui, King, Dein, & O’Connor, 2008; Casarez & Miles, 2008; Gall, 2004; Gall & Cornblat, 2002; Harris et al. 2013; Krause, 2002).

Further delineation of one’s relationship with God and manner of interactions defining the relationship allows for a more specific method of assessment of the association between one’s relationship with God and their mental/physical health and disease adjustment. Pargament and colleagues (2000) have outlined four coping styles in which one may interact with God in coping with problems in life: collaborative, active surrender, passive deferral, and self-directed. These coping styles are often described in relation to control – a hypothesized mechanism linking religious coping with health outcomes and adjustment. Collaborative religious coping is seeking control over a stressful situation through a partnership with God in solving problems. Responsibility for attaining control is held jointly; the person is not seen as a passive recipient of control (Pargament et al., 1988). Self-directed religious coping is seeking control directly through personal initiative rather than help from God. This style of coping reflects a view of an abandoning God or of a general lack of interest or belief in God (Phillips, Pargament, Lynn, Crossley, 2004). Passive deferral represents coping by waiting for God to control the situation (e.g., “Didn’t try much of anything, simply expected God to take control”). Active surrender represents an active yielding of control to God (e.g., “Did my best and then turned the situation
People using this method do not passively wait for God to solve their problems but take actions to relinquish their will to God’s rule (Wong-McDonald & Gorsuch, 2000). Taken together, these styles of interacting with God to solve problems in one’s life represent potential means of gaining control in a potentially uncontrollable situation.

The four styles of interacting with God to problem solve and gain control defined by Pargament et al. (2000) have emerged through qualitative inquiry with people coping with illness. Casarez et al. (2008) interviewed 38 African American mothers with Human Immunodeficiency Virus (HIV) in an attempt to understand how they used spirituality to cope with their illness. A content analysis of the patient narratives revealed that the women dealt with their illness through a relationship with God. Further analyses suggested that the women felt like partners in this relationship. The women felt as if their active participation with God in healing and assisting with their health was a requirement, which was fulfilled through engaging in private religious practices (e.g., prayer, reading the Bible, etc.). In this way, the women were engaging in collaborative coping.

Similar results emerged in a study of women with breast cancer (Gall & Cornblat, 2002). Participants were asked to write about how their religion and spirituality played a part in coping with their illness. Content analyses of the women’s writings suggested that their relationship with God played an integral role. In addition, the women experienced shared responsibility for coping. However, this shared responsibility was sometimes accompanied by surrendering to God’s will when they perceived the situation was too much to handle of their own accord. In this way, the women were both actively engaged with taking personal responsibility for coping and engaged in yielding control to God. This represents an active surrender coping style. Some
women noted a negative relation with God which was undergirded by feeling as if God caused the illness. These women did not rely on God and used a self-directed coping style.

Polzer and Miles (2007) developed a theoretical model defining the role of spirituality in self-management of diabetes among African American men and women. Analysis of narratives conducted during minimally-structured interviews indicated that self-management through a relationship with God was the primary theme underlying their coping. Furthermore, three styles of interacting with God were defined: God is in the Background, God is in the Forefront, and God is Healer. People using the God-is-in-the-Background style predominantly accepted responsibility for managing their illness and recognized that God was a supportive partner. These people viewed their relationship as collaborative, with the individual being actively engaged in self-care practices which were supported by God. For people in the God-is-in-the-Forefront style, God, rather than the person, was seen as the major actor in diabetes management. These people did not see themselves as working collaboratively with God; they were more submissive and yielded to God’s authority. In this way, they surrendered to the power of God. Importantly, people remained engaged in health-related self-management practices, but felt as if they were being led by God and believed that their strong faith that God would improve their health was an important prerequisite to any benefits that stemmed from the management practices. This closely resembles active surrender coping. For the last group, God is Healer, people deferred the responsibility for diabetes management to God – utilizing a passive deferral approach. They believed that, if one has sufficient faith in God, God would heal them of their disease.

The three aforementioned studies tapped into a key concept of the religious coping used by older adults – the nature of one’s relationship with God and one’s means of interaction with
God. Qualitative research in this area has been fruitful in exploring people’s experience with interacting with God to problem solve and gain control. This means of coping is a frequently occurring phenomenon of which we have an elementary understanding. Thus, one aim of the current study is to uncover the essence of this phenomenon. What is the nature of one’s experience with using this type of coping strategy? Additional qualitative inquiry in this area would increase our understanding of a complex and dynamic relationship. What is the nature of older adults’ experience with this relationship? What is the nature of this interaction within the context of coping? The resultant knowledge obtained from such studies would progress our ability to understand the association between one’s religious coping styles (particularly their relationship with God) and physical and mental health.

Control

Religious coping styles and one’s relationship with God have been suggested to impact one’s physical and mental health. Research has attempted to assess the mechanism of change that underlies this effect. Locus of control has been noted frequently as an underlying mechanism (Fiori, Brown, Cortina, & Antonucci, 2006; Fiori, Hays, & Meador, 2004; Gall, 2004; Holt, Lewellyn, & Rathweg, 2005; Holt, Clark, Kreuter, & Rubio, 2003; Siegal & Schrimshaw, 2002).

Rotter (1954) noted that control can be conceptualized by a dimension ranging from internal locus of control to external locus of control; people either tend to view reinforcements as stemming from their own actions (internal control) or from outside forces (external control). Outside forces include such things as fate and powerful others. God is often regarded as a powerful other; consequently, people who rely on God when coping are thought to have an external locus of control.
Relying on God when coping has been viewed to be detrimental to one’s level of perceived personal responsibility for enacting health behaviors. This mindset may be based on the assumption that people who rely on God when coping have a fatalistic and deferring style of “letting God do all of the work.” Indeed, some people enact this mindset as exemplified by the God-is-Healer typology delineated by Polzer and Miles (2007) or passive deferral coping defined by Pargament et al. (2000). As has been noted previously, there are different styles of interacting with God when coping which may elicit different senses of control. For example, people using a collaborative style of coping may have a higher sense of internal control. This is not surprising given that people who use this style of coping see God as a partner and retain personal responsibility for their health and health practices; God is seen as a partner and supporter.

Paradoxically, people who use an active surrender approach to religious coping not only fail to report a decrease in personal control, but sometimes evidence increased internal control (Cole & Pargament, 1999; Gall & Cornblat, 2002; Pargament & Hahn, 1986). In Gall & Cornblat’s (2002) qualitative study of women with breast cancer, the women stated they did not feel as if they had lost personal control by surrendering. Rather, they reported a release from burden; potentially driven by a greater degree of acceptance of the situation. Notably, older adults may be more apt to attain or maintain a sense of internal control while using a surrender-style coping than younger adults (Fiori et al., 2006).

It has been noted that control is a complex, multifaceted construct (Shapiro, Schwartz, & Astin, 1996). Multiple attempts have been made to incorporate religiosity and God into conceptualizations of control. For example, there are currently scales for the measurement of spiritual health locus of control (Holt et al., 2003), God locus of control (Wallston, 1999), and two scales of divine control (Schieman, Pudrovskas, & Milkie, 2005; Umezama et al. 2012). All
conceptualizations attempt to assess the extent one perceives that God is responsible for management of aspects of one’s life or the extent that God controls the outcome; the scales vary regarding the level of responsibility of the person and the extent one can effect change in an outcome. Regarding spiritual health locus of control, two dimensions have been defined: active and passive. The former involves a mindset in which God empowers people to take actions and care for themselves whereas the latter involves a mindset in which the power is with God to protect one’s health. These dimensions have been shown to be distinct from internal and external control beliefs. Notably, both active and passive dimensions were positively related to internal control. At present, the extant literature is unclear regarding the ways that one’s spirituality and perceptions regarding God impact control beliefs. Additional research in this area is needed.

Locus of control and spiritual locus of control represent perceptions of control. Alternatively, the motivational theory of life-span development explains control processes from a striving or motivational perspective. In their motivational theory of life-span development, Heckhausen and Schulz (1995) proposed that developmental adaptation occurs to the extent to which one realizes control of one’s environment (Heckhausen, Wrosch, & Schulz, 2010). A main tenet of this theory states that one is motivated and strives to meet goals through primary and secondary control processes. Primary control processes are meant to alter one’s immediate external environment (e.g., health engagement practices), whereas secondary control processes are directed at creating change within one’s self (e.g., decreasing the importance of a once-sought-after goal, etc.). One is constantly striving to maximize primary control capacity; consequently, secondary control processes are meant to increase one’s ability to engage in primary control processes and minimize losses in primary control capabilities. One’s use of
secondary control strategies changes over the life course (Heckhausen, Wrosch, & Schulz, 2010). As one transitions from midlife to older adulthood, secondary control striving increases while primary control processes remain stable.

The motivational theory of life-span development is relevant to our understanding of an older adult’s behavior when coping with health decline and functional limitations. Notably, the context of one’s illness plays an important part in the role and effect of primary and secondary control on one’s well-being because optimizing control is contingent on matching one’s environment (opportunities for control) with one’s control strategy (Heckhausen & Schulz, 1998). For example, enactment of primary control processes (goal engagement/health engagement strategies) led to better health outcomes among older adults with acute health problems as opposed to those with chronic health conditions (Hall, Chipperfield, Heckhausen, & Perry, 2010). In addition, Hall et al. (2010) found that disengaging with health related goals (a secondary control process) led to better health outcomes among older adults with chronic health conditions as opposed to those with acute conditions. Context is important.

One’s interactions with God when coping – defined by one’s relationship with God – might be defined as secondary control processes. For example, older adults who utilize a collaborative or active surrender coping style might be using primary control processes by engaging in the health practices for which they can elicit change and then secondary control processes by relying on (or surrendering to) God after they feel as if their own actions would be insufficient or additional efforts would be futile. In this way the person retains motivational power to work on something that can be changed through primary control - and thus the secondary control practice has achieved its goal. Conversely, among those with a relationship with God, the use of passive deferral or self-directed coping either completely relies on primary
(i.e., self in self-directed) or secondary control processes (i.e., God in passive deferral). It might be detrimental to rely completely on primary or secondary control practices, as one’s hierarchy of goals likely contains those for which one strategy is more appropriate than another; however, both strategies are useful somewhere within the hierarchy and their utility is based on the context (e.g., presence of chronic or acute condition). More research in this area is necessary to uncover the primary and secondary control processes as they relate to one’s relationship with God with coping.

Control beliefs are complex processes that have shown intricate relations to one’s interaction with God and God-relation coping style. More research is needed in this area to attain a clearer picture of the relation of these constructs. This represents one aim of the current study. What is the nature of the phenomenon of control when interacting with God when coping? How is control experienced in this context?

**Meaning-Based Coping**

One’s relationship and interaction style with God when coping have an effect on appraisal of control for an event in a stressful situation. This relationship has additional effects on one’s appraisal of an event. For example, one’s values and belief structure (such as religion and spirituality) may serve as an orienting system that affects interpretations and appraisals (Desai & Pargament, 2013; Jenkins & Pargament, 1995; Park, 2013). This system may become more salient when situations seem unchangeable, which occurs frequently with older adults dealing with chronic illnesses (Pargament, Ensing, Falgout, Olsen, et al., 1990).

Folkman’s (1997; 2008) revised model of the stress process allows for a powerful tool to understand the operations of this framework (see Figure 1).
Figure 1. Folkman (1997) revised transactional model of stress and coping.

Specifically, Folkman (1997) posited that people might resort to meaning-based coping when dealing with stressful situations that are not readily amenable to change. Furthermore, one’s value and belief system is frequently used to make positive interpretations of onerous events. Through this process people infuse their values with ordinary life events. For example, people with cancer may interpret their disease state as part of God’s plan for them. Interpreting their cancer within the lens of their values and beliefs acts to further support their values and beliefs and consequently provides meaning to everyday coping-with-cancer activities. This meaning-making process has been found to occur even when people attribute their illness or functional decline to aspects of God that are negatively valenced (God’s anger, etc.: Gall, 2004). Although meaning and understanding were enhanced by interpreting events within their religious values and beliefs, these individuals displayed poorer emotional functioning than those who saw God as
benevolent. Thus, one’s religious and spiritual beliefs play an important role in an orienting system that works to create meaning out of stressful events. The God-relation and interaction styles people exhibit are significant as well and affect one’s functioning.

Creating positive appraisals and interpreting a negative situation with a positive valence lies at the core of meaning-based coping. One’s value and belief system – which affects one’s relationship with God when coping – is a salient factor in both one’s ability to reappraise the situation and the manner in which one reappraises the situation. Revision of goals also represents an important aspect of meaning-based coping. The revision of goals represents a secondary control process. As noted previously, one’s relationship with God might be related to the manner in which one engages in secondary control process goal revision. Acceptance represents a potential outcome of a goal-revision process and has received increasing research attention (Hayes, Luoma, Bond, Masuda, and Lillis, 2005).

Acceptance

Situations in which people are confronted with unalterable negative circumstances often produce stress and a host of negative emotions. There is a type of psychotherapy that may be particularly beneficial for the treatment of people in these types of situations, Acceptance and Commitment Therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2005). The basis of this therapeutic intervention is the acceptance of suffering. Once suffering is accepted people are better equipped to focus on aspects of their lives which they value. Fundamentally, the therapy involves acceptance of suffering and commitment to engage in meaningful activities. In terms of the motivational theory of life span development, by engaging in acceptance and committing to valued actions, one has made a decision to disengage from an unachievable goal (secondary control process) and opted to engage in goals with positive valences which they are capable of
meeting. Engagement in this process supports agentic action and sustains primary control capacity – the purpose of secondary control endeavors.

One’s relationship with God and religious coping style are pertinent to both acceptance and commitment. For example, women in the study by Gall and Cornblat (2002) who used a surrender style coping reported that they did not lose personal control by surrendering. Rather, they noted experiencing release from burden. It might be that the relationship with God these women used during coping enhanced their acceptance of the situation – or ability to disengage from a harmful goal. In addition, Gall and Cornblat (2002) concluded from the women’s narratives that they experienced a positive attitude by surrendering, noting that the attitude was not denial – or the type of avoidance which hinders acceptance – but rather their expression of a personal choice regarding the aspects of life that they were going to value (i.e., commitment). This experience mirrors the tenets of ACT: accept suffering rather than spend energy trying to avoid the experience and commit to engage in activities one values. Acceptance has been deemed to be an important aspect of coping with suffering and might have therapeutic value. This construct is particularly appropriate for examination within older adults attempting to cope with chronic illness and functional decline given that these might not be readily amenable to change.

The process of acceptance and the emotional responses that follow the attainment of acceptance can be described by the theory of meaning-based coping and understood by the motivational theory of life span development. It has been stated that one’s relationship with God likely plays a role in the manner that one attains acceptance and one’s ability to attain acceptance; however, it is unclear what effect each religious coping style has on one’s manner of achieving it and ability to attain it. Therefore, the following research questions emerge: What is
the nature of acceptance for people using religious coping to deal with chronic illness and functional limitations? How is acceptance related to one’s relationship with God when coping?

The discussion heretofore has centered on describing aspects of the stress process that are affected by, or potentially influence, one’s use of religious coping styles that involve God. Race/ethnicity has repeatedly shown salient relations with religiosity and merits discussion.

**Race/Ethnicity**

Regarding religion, African Americans have been found to report higher religiosity (Levin, Taylor, & Chatters, 1995; Musick, Koenig, Hays, & Cohen, 1998; Taylor, Chatters, & Jackson, 2007) and more frequent use of religious coping (Dilworth-Anderson, Williams, & Gibson, 2002; Taylor et al, 2007) than Whites. African Americans have been shown to report using collaborative coping, self-directed coping, and religious deferral more frequently than Whites (Dunn & Horgas, 2004). In a study by Harris (2011), African Americans reported a significantly higher frequency of use of collaborative, active surrender, and passive deferral coping than did Whites. Notably, in a qualitative study of ill, older, rural adults, African Americans were more likely to discuss God using interpersonal language and more likely to associate their relationship with God to their health (McAuley, Pecchioni, & Grant, 2000). Differences have been noted between African Americans and Whites in religiosity, religious coping, one’s relationship style with God in coping, and one’s interaction with God when coping. Polzer & Miles (2007) noted that religion and religious coping have often been characterized by European-American-centered conceptualizations which frequently do not incorporate African American history and culture. Research using qualitative methods is uniquely poised to explore religious coping styles among a diverse group. A rich understanding of potentially complex differences between African Americans and Whites will likely stem from
a methodology in which participants are free to elaborate on their lived experience. Notably, salient racial/ethnic differences emerged from thesis research by Harris (2011). Consequently, one aim of this study is to explore potential differences between African Americans and Whites on key study phenomena.

The four styles of coping outlined by Pargament and colleagues (2000) seem to be important for older adults dealing with disease and functional impairment; however, the generalizability of the quantitative assessment of these constructs in a culturally competent manner across diverse populations is questionable. Pargament and colleagues’ (1988) original validation of the RCOPE religious methods of gaining control three-factor scale (i.e., collaborative, passive, and self-directed) was conducted with a sample that was 100% White. Later work on the four-subscale version was only slightly better in inclusion of non-White individuals: 92% White [college sample], 62% White [hospital sample: no further information was provided on the racial/ethnic breakdown of minority participants] (Pargament et al., 1998) and 93% White (Pargament et al., 2000). These studies demonstrated poor racial diversity. A qualitative exploration of the quantitative scale assessing these constructs would enhance understanding of scale items. Such qualitative exploration should be conducted with a sample not dominated by White participants and could be conducted using cognitive interviewing. Cognitive interviewing includes an assessment of participants’ comprehension of items as well as the decision-making and response-formation processes involved in answering items (Tourangeau, 1984). Consequently, a goal of this study is to explore White and African American older adults’ understanding and interpretation of an RCOPE subscale.
**Thesis Research Related to the Current Study**

My thesis research used mixed methods to explore one aspect of the Folkman (1997) stress process model. Specifically, using quantitative methods, meaning in life was tested as a mediator of the relation of religious coping styles involving God (i.e., RCOPE subscale) and emotional outcomes (i.e., depression symptoms, positive aspects of caregiving, stress-related growth, and religious growth). Tests of the bivariate associations of study variables were conducted as were tests regressing mastery onto the religious coping styles. The effect of race/ethnicity on variables of interest was also assessed. Participants included 35 non demented care recipients with advanced, chronic illness and 35 family members providing care to this group. This sample included approximately equal numbers of Whites and African Americans. Results indicated that meaning in life was not a mediator of religious coping styles and emotional outcomes. Bivariate associations suggested that the relation between the religious coping styles, meaning in life, and emotional outcomes varied by race/ethnicity.

In addition, in-person semi-structured qualitative interviews were conducted to provide an exploration of key study variables and their relations (Harris, Allen, Dunn, & Parmelee, 2013). Qualitative content analyses were conducted for care recipients and caregivers separately. Results of the qualitative and quantitative methods converged in several areas: within this sample the consequence of religion/spirituality was largely the creation of positive emotion, and religious coping styles were not related to meaning in life or a sense of mastery. The brief qualitative interviews (average length of interview was under ten minutes) produced meaningful understandings of study constructs. Three overarching themes emerged. First, spirituality/religion/relationship with God was extremely important. Across participants, the experience of religion and spirituality and relationship with God was interpreted as a primary
aspect of living and coping with advanced, chronic illness. When facing a stressful situation – either having an advanced, chronic illness or caring for a loved one with a chronic illness – religion, spirituality, and a relationship with God were noted as fundamental. The second overarching theme related to God being described as a provider. The thing that participants described most as being provided by God was strength, followed by perspective and hope. The third pervasive theme stemmed from the participants’ description of their relationship with God. Specifically, they characterized the relationship as a true, personal, intimate relationship, which included various ‘interpersonal’ interactions. Participants noted that they “talk with God,” “walk with God,” that God is “with” them, and that God is “close.” Participants often described their relationship with God in terms one might use to describe a relationship with another person.

Understanding of religious coping and one’s relationship with God when coping was enhanced by the emergence of these themes out of the lived experience of the participants in my thesis; however, the findings were more descriptive than interpretive and are only a beginning in the search to understand the complex and dynamic nature of one’s relationship with God when coping with functional impairments. The current study aimed to continue this search.

Two aspects of my thesis provided an important impetus for the development of the current study: the nature of the RCOPE data and the richness of participant narratives collected during brief qualitative interviews. Regarding the RCOPE data, the correlation matrices charting the associations of the RCOPE with study variables were markedly different when grouped by race/ethnicity. By itself, this is not surprising given that the literature suggests racial/ethnic differences among many of the relations assessed in the study. The nature of the differences in the matrices is what implies potential problems with the ability of the RCOPE to assess religious coping styles among African Americans. Tables 1 and 2 display differences between
racial/ethnic groups for care recipients and caregivers, respectively. Examination of the
correlation matrices among the four groups in the study (i.e., White care recipients, White
caregivers, African American care recipients, African American caregivers) demonstrated a
pattern of relations moderately consistent with previous literature when examining those of the
White participants.

Table 1

*Bivariate Correlations of Study Variables among Care Recipients*

<table>
<thead>
<tr>
<th></th>
<th>Stress Growth</th>
<th>Religious Growth</th>
<th>CESD</th>
<th>Mastery</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative</td>
<td>.60*/-.07</td>
<td>.70*/-.12</td>
<td>.19/-13</td>
<td>-.22/.13</td>
<td>.23/.25</td>
</tr>
<tr>
<td>Active surrender</td>
<td>.74*/-.12</td>
<td>.63*/-.22</td>
<td>.19/.38</td>
<td>-.43^/-48^</td>
<td>.39/.12</td>
</tr>
<tr>
<td>Passive deferral</td>
<td>.31/.16</td>
<td>.29/-12</td>
<td>.12/.29</td>
<td>-.42^/-74*</td>
<td>.01/.33</td>
</tr>
<tr>
<td>Self-directed</td>
<td>-.79*/-.09</td>
<td>-.59*/-.20</td>
<td>.02/.11</td>
<td>.51*/-.03</td>
<td>-.35/-37</td>
</tr>
</tbody>
</table>

*Note.* White care recipient r value/African American care recipient r value. CESD = Center for Epidemiological Studies Depression Scale, *p < .05, ^ = .05 < p < .1. Due to missing data the number of participants in each analysis ranged from 19 to 20.

Table 2

*Bivariate Correlations of Study Variables among Caregivers*

<table>
<thead>
<tr>
<th></th>
<th>Stress Growth</th>
<th>Religious Growth</th>
<th>CESD</th>
<th>Mastery</th>
<th>PAC</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative</td>
<td>.69*/.14</td>
<td>.77*/.18</td>
<td>-.01/-17</td>
<td>.05/-12</td>
<td>.38/-12</td>
<td>.23/.37</td>
</tr>
<tr>
<td>Active surrender</td>
<td>.61*/.58*</td>
<td>.68*/.37</td>
<td>-.12/-25</td>
<td>.00/.37</td>
<td>.29/.26</td>
<td>.07/.41</td>
</tr>
<tr>
<td>Passive deferral</td>
<td>.05/.13</td>
<td>.17/.20</td>
<td>.70*/-.20</td>
<td>-.52*/-.20</td>
<td>.01/-20</td>
<td>-.67*/.21</td>
</tr>
<tr>
<td>Self-directed</td>
<td>-.68*/-.64</td>
<td>-.85*/-.10</td>
<td>.22/-38</td>
<td>-.13/-38</td>
<td>-.62*/-.54*</td>
<td>-.31/-30</td>
</tr>
</tbody>
</table>

*Note.* White caregiver r value/African American caregiver r value. CESD = Center for Epidemiological Studies Depression Scale, PAC = Positive Aspects of Caregiving, *p < .05.
The matrices of the African American participants provide a stark contrast to those of the White participants. In addition, they are in contrast to what is predicted by previous research in this area.

One possibility is that the scale assessing the religious coping styles does not display measurement equivalence/invariance – it does not assess these constructs equally well among Whites and African Americans. As mentioned previously, the psychometric validation of the RCOPE did not include sufficient numbers of racial/ethnic minority respondents. When a scale does not have measurement equivalence, interpretation of scores and differences in scores across groups becomes questionable. It might be that there is dissimilarity between the relation of these latent variables proposed to be measured by the RCOPE and their observed scores. For example, a four-factor model – currently used in the RCOPE – might best capture the variance in responses among Whites, while a different factor structure might be better suited to assess the experience of African American’s religious coping. Moreover, individual items might elicit varying responses between White and African American individuals due to differences in interpretation of the wording of the items or due to differences in experiences with the constructs under study. The current research aims to explore both Whites’ and African Americans’ comprehension and understanding of RCOPE items through in-depth analysis of their lived experience. An additional aim of this endeavor is to explore the extent to which participants’ experience with coping mirrors the factor structure of the RCOPE.

Need For Study

Older adults’ engagement in religious coping practices that involve God has been discussed in relation to Folkman’s (1997) conceptualization of meaning-based coping and Heckhausen and Schulz’s (1995) motivational theory of life span development. Our
understanding of these coping practices is currently limited. In addition, control and acceptance are two constructs that display salient associations with religious coping styles involving God. The associations between control, acceptance, and religious coping styles can be described by Folkman’s (1997) model and potentially understood using the framework of the motivational theory of life span development; however, our current understanding of how specific religious coping styles are related to these constructs is underdeveloped. This study sought to further our understanding of each of these constructs and their relations. Previous research suggests that qualitative methods are useful in exploring religious coping methods among diverse groups. Consequently, an in-depth examination of African American and White older adults’ religious coping strategies using a qualitative methodology was conducted. In addition, control (both perceptions of control and control processes), acceptance, and their relations to religious coping styles involving God were explored using a phenomenological approach.

Research suggests that specific assessment of one’s religious coping style provides a powerful predictor of physical and emotional health adjustment when coping with stressful situations. Specifically, understanding one’s religious coping that involves relationship and interaction style with God is important; however, culturally competent measurement using the current assessment of these coping styles is questionable. Therefore, a qualitative examination of the RCOPE subscale – using cognitive interviewing – among African American and White older adults was conducted.

Racial/ethnic differences in religiosity and religion have been found repeatedly among African American and White older adults. Attaining a deeper understanding of the ways in which these groups diverge in regards to religious coping styles and other study phenomena has
important implications. Thus, an exploration of potential differences in study phenomena among African American and White older adults coping with functional impairments was conducted.

**Research Questions**

The aims of this study were threefold. The research questions stemmed from these higher-order aims. The phenomena under study were embedded in the context in which our participants experience them; therefore, describing the context of the phenomena – as well as the phenomena themselves – was important to this study. First, within the context of coping with functional limitations, explore the nature of older adults’ relationship with God and their God-person interaction style. Specifically, this study was interested in exploring the lived experience of relationship with a monotheistic God. In addition, we sought to understand – among older adults who report having a relationship with God – how control and acceptance are experienced during the process of coping with functional limitations. Thus, key research questions included: (a) What is the nature of one’s experience with using a religious coping strategy? (b) What is the nature of older adults’ experience with their relationship with God in the context of coping? (c) What is the nature of their interaction with God within the context of coping? (d) What is one’s experience of control in a religious coping context? (e) What is one’s experience of acceptance in this context?

Second, this study aimed to explore participants’ understanding of a standard measure of religious coping. Key research questions included: (a) How do older adults comprehend items on the RCOPE subscale? (b) What is the decision-making and response-formation process undergone when answering these items?

Third, this study aimed to explore potential convergences and divergences in the nature of study phenomena between African American and White participants.
METHOD

Participants and Setting

Participants were recruited from assisted living facilities, older adult activity centers, residential care settings, churches in and around Tuscaloosa, and from The University of Alabama Center for Mental Health and Aging’s Older Adult Participant Database. Recruitment methods included distribution of flyers at these sites, penny auctions, use of a community recruiter, and snowball sampling in which participants referred others whom they thought would enjoy participating. Participants were purposefully recruited based on four criteria: self-reported presence of a relationship with a mono theistic God, age (60 or above), presence of functional impairment, and race/ethnicity (White or African American). Adequate level of functional impairment was indicated by a score of three or above on the Vulnerable Elders Survey (VES-13), a score predictive of increased risk of functional decline and/or death within 11 to 34 months (Min, Elliott, Wenger, & Saliba, 2006). Notably, a participant can obtain a score of three on the VES-13 if they are 85 or older (i.e., solely due to age). For participants who met this age criterion, at least one additional point was needed to be attained from elsewhere on the VES-13 for the individual to be eligible for the study. If potential participants were found to have an adequate level of functional impairment, they were screened with the St. Louis University Mental Status Examination (SLUMS). An education-adjusted score in the normal or mild neurocognitive disorder range (20 to 30 or 21 to 30, depending on level of education) indicated that participants were able to give an accurate description of their experiences regarding study phenomena, and were subsequently taken through informed consent procedures.
Based on the ideographic nature of the proposed study, a sample size of 20 to 24 was proposed. Notably, Norlyk and Harder (2010) state that the size of a sample in a phenomenological study is considered adequate when investigators can make clear interpretations, meaning units noted in narratives become redundant with those found previously, and new participants are not revealing new findings. Sixty-five potential participants who had provided their name and contact information on a recruitment flyer or through the participant database received up to three contact attempts. Of these 65, 23 were no longer interested or were unable to be contacted, 13 did not endorse an adequate level of functional impairment on the VES-13, and four exceeded acceptable level of cognitive impairment for study inclusion as indicated by scores on the SLUMS. Phenomenological and cognitive interviews were completed with 25 participants for this study (12 White, 13 African American), a sample size recommended for phenomenological research (Sandelowski, 1995).

**Measures**

Demographic information was collected from each participant. Information included age, race/ethnicity, gender, and primary religious affiliation. Perceived income adequacy was assessed with a single question (i.e., “how difficult is it for you to pay for the very basics like food, medical care, and housing?”) with response options ranging from 1 = *Not at all difficult* to 4 = *Extremely difficult*.

**St. Louis University Mental Status Examination (SLUMS; Tariq, Tumosa, Chibnall, Perry, Morley, 2006).** The SLUMS is a brief mental status exam that assesses orientation, memory, attention, and executive function domains (see Appendix 1). Scores range from 0 to 30. Scores fall in one of three education-adjusted categories – “normal,” “mild cognitive impairment/mild neurocognitive disorder,” and “dementia.” For individuals with less than a high
school education the score ranges include the following: normal (25-30), mild neurocognitive disorder (20-24), and dementia (1-19). For individuals with a high school education the score ranges include the following: normal (27-30), mild neurocognitive disorder (21-26), and dementia (1-20). The SLUMS has been shown to be a specific and sensitive indicator of both mild cognitive impairment and dementia among older adults (Tariq, et al. 2006).

**Vulnerable Elders Survey (VES-13; Saliba et al., 2001).** The VES-13 is a 13-item measure using a function-based scoring system that considers age, self-rated health, limitation in physical function, and functional disabilities in the identification of older adults at risk of functional decline and death (see Appendix 2). Validation of the VES-13 has shown that the estimated combined risk of death and functional decline within 11 months rose from 23% among older adults with VES = 3 to 60% among older adults with VES = 10 (Min, Elliott, Wenger, & Saliba, 2006). Thus, the VES-13 is a promising tool for identifying older adults at risk of death or functional decline within 1-2 years.

**Brief Religious Methods of Coping to Gain Control Subscale (RCOPE; Pargament et al., 2000).** The subscales of the RCOPE are meant to serve as theoretically based and functionally driven means of assessing religious coping (see Appendix 3). Four specific coping styles are assessed using three items each. Items assess the frequency that respondents use each form of coping ($1 = \text{not at all}, 4 = \text{a great deal}$). Scores for each grouping of three items range from 3 to 12, with higher scores representing greater frequency of use. Collaborative coping items assess methods that seek control through a partnership with God (e.g., “Worked together with God as partners”). Active surrender items assess an active giving up of control to God in coping (e.g., “Did what I could and put the rest in God’s hands”). Passive deferral items examine passively waiting for God to control the situation (e.g., “Didn’t try much of anything;
simply expected God to take control”). Self-directed items assess seeking control directly through an individual initiative rather than help from God and eschewing need for or reliance on God (e.g., “Made decisions about what to do without God’s help”). Although the three-item versions of the coping subscales have been used in previous studies, indicators of their internal consistency were not provided; however, information for subscales with larger items is available. Internal consistencies for five-item scales have been shown to be .83 and .92 for passive deferral and active surrender, respectively. An eight item-version of the collaborative coping was found to have an alpha of .89 (Pargament et al., 2000). A 12-item scale of self-directed coping was found to have an internal consistency of .94 (Pargament et al., 1988). Notably, the samples used in these studies contain insufficient numbers of non-White individuals; there is need for further validation.

**Methodological Approach**

The quintessence of the first aim of the study is the search for the nature of older adults’ relationship with God, their God-person interaction style, and sense of control and acceptance during coping. The nature of the constructs of interest is important as are the ways in which they are experienced. In addition, important to the understanding of one’s coping is the context in which it takes place. Given the nature of the research questions, an interpretive phenomenological methodology was used – also frequently termed ‘Heideggerian’ or ‘hermeneutic’ phenomenology.

Interpretive phenomenology is based on the philosophy of Heidegger (Heidegger, 1962). The Heideggerian philosophy of phenomenology contains many key points that made interpretive phenomenology as a research methodology a good fit for use within this study. Heideggerian phenomenology separates itself from an earlier form of phenomenology – Husserlian – partly due to the inclusion of context in one’s understanding of people’s experience.
Husserl believed that context was not a key factor while Heidegger believed that the understanding of a phenomenon via the lived experience of people does not occur in isolation of the context in which they live – both the participants and researchers (Wojnar & Swanson, 2007). For example, Husserl posited that one can have an understanding of one’s experience and that the researcher could determine the universal, decontextualized essences of one’s experience through the person’s description of it. Heidegger posited that one’s experience cannot be separated from the world in which s/he lives; consequently, any attempt to understand the nature of a phenomenon must be interpreted within the context of one’s experience within the ‘lifeworld’, or ‘being-in-the-world’ (Heidegger, 1962). This distinction has important consequences for the methodology that stems from each perspective (Lopez & Willis, 2004). For example, Husserlian phenomenology would advocate exploring experience as a means to an end – to uncover the essence of a phenomenon – whereas Heideggerian phenomenology advocates exploring the experience itself as well as experience as an indicator of the nature of a phenomenon (Caelli, 2000). Both the context of experience and the experience itself are important to this study. Age, race/ethnicity, type of illness and functional decline all represent contexts that influence one’s experience. Furthermore, the nature of one’s relationship with God represents a salient factor when exploring use of this relationship to cope with health and functional impairments. A decontextualized account of the phenomenon of interest would not be sufficient to answer the research questions of this study; thus, an interpretive phenomenological approach was used.

Heidegger’s concept of the inseparable nature of context from experience and consciousness/understanding of the experience affects the role of the researcher in interpretive phenomenological research. Husserlian phenomenology advocates for bracketing. Bracketing is
described as an attempt to relieve oneself of preconceived perceptions and judgments about the phenomenon under study and attain neutrality (Wall, Glenn, Mitchinson, & Poole, 2004). In this way, the researcher seeks to transcend the experience – and interpretation of the experience – to describe the phenomenon. Heidegger (1962) noted the improbability of describing experience without interpretation. Indeed, interpretation is important and undeniable. Consequently, the interpretive approach was deemed to be more appropriate than a Husserlian descriptive approach.

Although bracketing was not used in this study, it is recommended that one acknowledge the perspective one brings into the research. Heidegger (1962) discussed the hermeneutic circle of understanding in which the researchers come to comprehend the meaning and nature of phenomena by recognizing their own assumptions and interpreting the experience of the participants. Thus, the researchers’ final comprehension of participants’ meaning of a phenomena resulted from participant experience, researcher understanding, and data from other sources (i.e., previous research findings, etc.: Wojnar & Swanson, 2007).

The second aim of the study was based on the potential inadequacy of the RCOPE subscale to assess religious coping styles among non-White samples. Cognitive interviews were used to accomplish this aim. This strategy was used for its potential to not only explore participants’ understanding regarding each aspect/construct within the scale (collaborative, active surrender, etc.), but also to explore the decision- and response-making process for each item and grouping of items intended to measure a unique construct. Participants’ responses assisted in the determination of the presence of racial/ethnic divergences in responses as well as the potential reasons for these differences.
**Procedure and Analyses**

Once a participant was screened and deemed eligible for the study, an appointment was made for a visit. Participants were encouraged to spend time thinking about their relationship with God and the ways that it was associated with coping with health issues and functional impairments. Participants were given a description of the study and informed consent was obtained. Narrative interviews guided by the interpretive phenomenological approach were conducted first, followed by a cognitive interview regarding the RCOPE subscale. The cognitive interviewing was conducted last in order to not prime the participants regarding phenomena under study. All interviews were conducted by the principal investigator. The first interview was transcribed by the principal investigator. All subsequent interviews were transcribed verbatim by a professional medical transcriptionist.

**Interpretive phenomenological interviews and data analysis.**

It is important to denote why a certain philosophical approach is chosen and to clarify how the principles of the philosophical approach are implemented (Norlyk & Harder, 2010; Stubblefield & Murray, 2002). The choice of an interpretive phenomenological approach is described above. Guidelines for implementing an interpretive phenomenological approach as well as analysis for this approach have been developed (Benner, Tanner, & Chesla, 2009; Crist & Tanner, 2003; Smith & Osborn, 2003). The interpretive phenomenological research method involves an iterative process and is consequently nonlinear. It involves a simultaneous “process of interviewing, observing, identifying lines of inquiry, and interpreting” (Crist and Tanner, 2003, p. 204).

The interpretive team consisted of Drs. Allen and Durkin and me, with me acting as the primary interpreter. Due to the iterative process of interpretive phenomenology, a semi-structured interview was used. Initial interview questions were scripted (see Appendix 4);
however, these questions were altered, deleted, and/or accompanied by additional questions stemming from the emergence of new lines of inquiry as each interview progressed.

Interpretive phenomenological inquiry requires a discussion of investigator assumptions subsequent to and simultaneously with interpretation. Because people are inextricably situated in their worlds, one cannot bracket preconceived notions and understanding of the study phenomena, but must acknowledge the assumptions that influence interviews and the process of interpretation (Crist & Tanner, 2003; Smith & Osborn, 2003). Heidegger (1962) described this process as the forward arc of the hermeneutic circle – where interpretation is the return arc. A meeting with the interpretive team (GMH, RSA, DD) was held before interviews began to provide a venue for discussion of biases, preconceived notions, and thoughts regarding the phenomena under study. The interpretive team continued this process informally throughout the phases of interpretation and interviewing. Early on, special attention was paid to potential ways in which preconceptions held by the interviewer were affecting interviews. Importantly, these efforts did not represent bracketing. The purpose of these ongoing activities was to shed light on how assumptions were affecting the interpretive team’s understanding of the participants’ lived experience – and were not meant to serve as a means of ridding oneself of the assumptions. The forward arc of the circle allows interpretive team members to understand how they perceive the possibilities of the phenomena and to open themselves to the phenomena occurring in a novel way – in relation to interpreters’ preconceptions (Brenner, Tanner, & Chesla, 2009).

Crist and Tanner (2003) have delineated four phases relevant to obtaining and analyzing information, which guided our process. Interpretation occurred during all phases. The first phase included critical evaluation of the interviewer’s technique with particular attention paid to information that was missing. Also, interpretive discussion of the preliminary interview
transcripts occurred. This initial review served to guide discussion regarding additional lines of inquiry as well as to hone current lines of inquiry. **Phase two** focused on the identification of “central concerns” (i.e., salient, emergent themes) and meanings. **Phase three** represented a time during which shared meanings became more evident. Interpretive team discussion of writing and transcripts continued into **phase four**. Additional lines of inquiry continued to emerge from discussions.

Benner, Tanner, and Chesla (2009) report that interpretive analysis is conducted in three main areas: analysis of paradigm cases, analysis of exemplars, and thematic analysis. Paradigm cases often provide a leap in understanding and represent strong patterns of the study phenomena and salient ways of being-in-the-world that assist the interpretive team in understanding the experience of the participants. Mutual agreement among the analysis team on which cases represent paradigm cases occurred throughout data collection and analysis. Paradigm cases might cause a shift in interpretive team understanding of phenomena; however, it was important that the team not attempt to construct too much of a generalized account of a phenomenon from one or even several paradigmatic cases. Paradigmatic cases are defined as such because they stand out as salient. It was important that the experience of the participant producing the narrative was not taken too far from the lived world in which it was experienced. Benner, Tanner, and Chesla (2009) state of paradigm cases:

> The aim is not to identify abstract structures within action or basic social processes that underlie the action. Rather than making a theoretical move away from the action-in-context described in the narrative, the interpreter tries to enter into a dialogue with the narrative, and to understand it through the concerns of the interpreter, but also to grasp the concerns and actions of the narrator. (p.448)

Although interpretation was enhanced through an exploration of what paradigmatic cases suggest about a phenomenon, all narratives were reviewed for what they made clear about the
phenomena. Indeed, all narratives were important for analyses. Analysis of narratives not
defined as paradigm cases represented exemplar analysis. Benner (1994) and Benner, Tanner,
and Chesla (2009) state that exemplar analysis involves careful exploration of each phenomenon
as it is expressed through narration of the participants’ lived experience. In this way, interpretive
team understanding was increased concerning the possibilities of the ways in which the
phenomena are experienced and the contexts in which they might occur. Through exemplar
analysis a bounded range of lived experience of the phenomena was obtained.

Thematic analysis represents the identification of broad understandings that stem from
narratives. Thematic analysis occurred concurrently with identification and interpretation of
paradigm cases and exemplars. Thematic analysis involved naming. Notably, Benner et al.
(2009) remark that the processes of naming and coding themes are disparate. Through a process
of naming the text, the interpreters attempted to “capture examples of patterns of meanings in
action, including salient context, that are evident in the text. The names are used to mark text
with related qualities of meaning for future retrieval, but the names never replace the text”
(Benner, Tanner, & Chesla, 2009, p.454).

The method of thematic analysis in interpretive phenomenology described by Smith and
Osborn (2003) was used for this study. An idiographic approach was used, which entailed
directing focus on the individual case, and slowly culminating to general themes which were
evident across narratives. This thorough review occurred in sets of four (two White and two
African American at a time). Although the process occurred in sets of four, the identification of
themes – indeed the entire analytic process – was iterative and built on prior analysis and
interpretation.
To conduct thematic analysis, a transcript under review was read several times to enhance familiarity with the narrative. Smith and Osborn (2003) recommend a three-step process to naming in thematic analysis. In the initial stage, during multiple readings, interpreters commented on sections they perceived to be salient, attempted to paraphrase or summarize sections, or pointed out contradictions in the narrative. There was no requirement regarding what was commented on; this first stage represented the investigators’ initial endeavor at understanding the phenomena under study as described in the life-world of the participant. The second stage involved naming of sections. This process was guided by comments that were made during the first stage. Again, although these names were meant to serve as abstraction of particular meaning units in the narratives, it was important that the interpreters remembered that the names were grounded in the contextual, lived-experience of the participants.

The interpretive team independently conducted these two stages for a set of interviews (four at a time). Subsequently, the team met and discussed the names that emerged through their interpretive processes. Interpreters’ analysis of each transcript was discussed and conversation developed when novel names emerged. Discussion targeting consensus was initiated when discrepancy among interpreters was noted. Through this process of determination of names, a list of salient meaning units was created and added to as the iterative process continued. After two sets of interviews were analyzed in this manner (eight in total) the frequency that novel meaning units emerged decreased substantially. As a consequence, the interpretive team re-evaluated the initial two sets with an emphasis on delineating names found in later transcripts than might have been missed in primary review. Thematic analysis continued in this manner for all interviews. Consequently, each aspect of participants’ narratives that was salient was marked as such and described through a name (a reference was made linking a section of text to a name). Oftentimes,
a section of text included multiple meaning units and was denoted with multiple names (multiple references were made).

Saturation and information redundancy were determined by interpretive team consensus and was guided by the lack of newly emerging names following this two-stage process. Once the team made this consensus determination, data collection ceased and the third stage of thematic analysis was initiated. The third stage of thematic analysis was conducted with the assistance of the software program Nvivo 10. This program provided assistance with organization of data and a structure for analyses based on the procedures used for this study. This stage of thematic analysis involved clustering of names in a logical manner and examination of meaning units across participants. Interpreters at this stage attempted to make sense of the names by clustering them and exploring potential connections. As in all stages of analysis, clustering of names must have made sense in relation to the original expression of the participants’ lived experience. In addition, this stage involved an inter case examination of names. In this way, similarities in meaning units across cases were explored (i.e., convergence). For example, every section of text that was referenced to be a representation of the meaning unit given the name “X” was analyzed at one time. Furthermore, comparisons among the same or similar names was made based on nuances within the text (i.e., divergence). This is the stage when substantial clarity regarding the nature of study phenomena became clear and processes were uncovered.

The third stage of thematic phenomenological analysis was conducted separately for White and African American participants. The aim of interpretation within group did not focus on delineation of racial/ethnic differences. Rather, the aim was to accurately describe and interpret the lived experience of each individual. After the interpretive team agreed that a thorough interpretation of the narratives in each group had been completed, an outline of
experience and expression of each name was available for each race/ethnicity. Areas of convergence and divergence emerged through intensive examination at this level.

**Cognitive interviewing.** Cognitive interviews were conducted using the concurrent, verbal probing technique (Willis, DeMaio, & Harris-Kojetin, 1999). During this process the participant was asked a question from the RCOPE subscale and was asked follow-up questions that probed for information regarding the answer given or the content of the question. Willis (2005) noted that the use of both scripted and spontaneous probes might be the most effective technique to obtain the greatest amount of relevant information. Thus, a semi-structured approach with scripted and spontaneous questions was used (see Appendix 5).

The purpose of the cognitive interviews was twofold: to explore the manner in which older adults comprehend items on the RCOPE and to better understand their decision-making and response-formation process when answering items. In addition to addressing these aims, analysis of cognitive interviews provided investigators with additional information regarding study phenomena (e.g., religious coping styles, control, and acceptance). Two forms of questions were asked: those that explored participants’ comprehension of ambiguous words or phrases which might illicit various meanings among participants (e.g., “turned the situation over to God”) and those that asked the participant to describe their lived experience with the behavior in question – as the participant comprehends the behavior. Of interest was the nature of the lived experience of the participants and the extent to which their experience mirrors the item structure – and consequently, the underlying theoretical factor structure – of the RCOPE. Therefore, once names were developed for each item, the interpreter explored for potential convergences and divergences among names for a grouping of items in the RCOPE (e.g., the three items that create the Passive Deferral subscale). Similar to the process described previously, the main level of
analyses was the individual participant; however, an exploration of themes across participants was conducted as well.

This study represents an in-depth, culturally competent examination of religious coping styles involving God, control, and acceptance among older adults living and coping with functional impairments. Interpretive phenomenology and cognitive interviewing strategies were used because they represent the methodologies best suited to answer the research questions. Interpretive phenomenology and subsequent analysis methods emphasize participant context and provided for a rich understanding of study phenomena as experienced by those living the phenomena.
RESULTS

Participants

Interviews with 12 White and 13 African American participants were conducted. The majority of interviews were conducted at the participant’s residences (80%) or a location of their choosing (16%, Tuscaloosa Public Library; 4% FOCUS on Senior Citizens). Descriptive statistics of the sample are included in Table 3.

Table 3

*Participant demographic information*

<table>
<thead>
<tr>
<th>Sample Characteristics</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Race of Participant</td>
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<tr>
<td></td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>(n =12)</td>
</tr>
<tr>
<td>M (SD)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>(n = 13)</td>
</tr>
<tr>
<td>M (SD)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Across Race</td>
</tr>
<tr>
<td>(N = 25)</td>
</tr>
<tr>
<td>M (SD)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demographics</th>
<th>White</th>
<th>African American</th>
<th>Across Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>72.7 (10.9)</td>
<td>72.7 (7.9)</td>
<td>72.7 (9.3)</td>
</tr>
<tr>
<td>% Women</td>
<td>100</td>
<td>85</td>
<td>92</td>
</tr>
<tr>
<td>SLUMS</td>
<td>27.3 (2.3)*</td>
<td>24.4 (2.5)*</td>
<td>25.8 (2.8)</td>
</tr>
<tr>
<td>VES-13</td>
<td>5.7 (2.2)</td>
<td>4.9 (1.9)</td>
<td>5.3 (2.0)</td>
</tr>
<tr>
<td>Financial burden</td>
<td>2.0 (0.9)</td>
<td>1.9 (1.0)</td>
<td>1.9 (0.9)</td>
</tr>
<tr>
<td>Interview length (minutes)</td>
<td>56.6 (13.8)</td>
<td>50.7 (10.3)</td>
<td>53.5 (12.2)</td>
</tr>
</tbody>
</table>

*Note. SLUMS = St. Louis University Mental Status Examination; VES-13 = Vulnerable Elders Survey; *p < .05. Financial burden (scale of 1 to 4 with higher scores indicating higher burden).*
Independent-samples t-tests were conducted to test for racial/ethnic differences in sample characteristics and interview length. African American participants had lower SLUMS scores $t(23) = 3.08, p = .005$. Furthermore, nine of the 13 African American participants’ SLUMS score fell in the mild neurocognitive impairment range compared to three of the 12 White participants’ scores. In this cohort of older adults (mean age = 72.7) in this geographic area, dissimilarity in quality of formal education may have contributed to differences in SLUMS scores. Religious denomination endorsement of White participants was as follows: four Baptists, three Methodists, and one each of Catholic, Church of God, Presbyterian, Lutheran, and Full Gospel. Among African Americans denomination endorsement included: 11 Baptists, one Methodist, and one Presbyterian. The participants reported a variety of medical conditions which caused functional impairments (see Table 4).

Table 4

*Participant illnesses and functional impairments*

<table>
<thead>
<tr>
<th>Condition</th>
<th>White</th>
<th>African American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscular-skeletal conditions including arthritis, degenerative disc diseases, etc.</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Cancer</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Vertigo</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Autoimmune Disorder</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Renal Disease</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Confined to a wheelchair</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Naming

Naming frequencies are for the entire sample. The first two stages of thematic analysis resulted in 32 names that were referenced in at least half of the participants’ narratives (with an additional 43 names that occurred with less frequency). Eighteen of these names were referenced in at least 80% of the narratives (with six being referenced in 100%). Through careful examination of the transcripts, the interpretive team made 3488 references linking a name to a section of text – with the majority of text that was referenced being linked to multiple references. The ten most frequently referenced names were: communication to God (362), God provides (357), do my part (244), intimacy of relationship (176), physical health (145), communication from God (132), relinquish (122), acceptance (111), faith (108), and presence of God (108).

Phenomenological Analysis

The participants’ language was not altered in any way. Narrative in italics represents respondent emphasis rather than interpreter emphasis. Table 5 includes a brief description of the major themes.

Nature of relationship with God. This section includes a description of the respondents’ relationship with God. Aspects of coping are included in this section; however, subsequent sections will be more directly targeting the ways that one’s relationship with God is associated to coping with health. As a consequence, these aspects will be revisited in subsequent sections. This section is focused on the nature of the relationship and describes the relational/interpersonal/God-person context in which coping occurs.
### Brief description of major themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimacy of relationship</td>
<td>An indicator of the quality of one’s relationship. Discussed in regard to: God’s presence, knowledge, and behavior.</td>
</tr>
<tr>
<td>Presence</td>
<td>One’s experience of God being physically present and/or God being available (promissory presence)</td>
</tr>
<tr>
<td>Communication to God</td>
<td>Primarily informal. Included four main content areas: request, command, inform, acknowledge. Enhanced when in need.</td>
</tr>
<tr>
<td>Communication from God</td>
<td>Primarily experienced as non audible. Experienced as sensations, physical feelings, thoughts, nature, others, intuition, and the outcome of situations.</td>
</tr>
<tr>
<td>God provides</td>
<td>Included provision in mental, emotional, and physical domains. Discussed in terms of problem- and emotion-oriented provision.</td>
</tr>
<tr>
<td>Reliance on God</td>
<td>Dependency requiring faith and trust in God. Enhanced through previous experience needing God’s assistance. Necessary but not sufficient in regards to health management and coping.</td>
</tr>
<tr>
<td>My part</td>
<td>One’s responsibility in the coping process – physical and mental. God expects one’s effort and use of what God has provided.</td>
</tr>
<tr>
<td>God’s will</td>
<td>God’s plan for the future. Indeterminate, yet thought to be for one’s good.</td>
</tr>
<tr>
<td>God’s time</td>
<td>Linked to the temporal occurrence of God’s will. Indeterminate.</td>
</tr>
<tr>
<td>Faith</td>
<td>Trust. Assurance in God’s omnipotence. Assurance that God will act on one’s behalf. Bolstered by previous experience and intimacy with God.</td>
</tr>
<tr>
<td>Relinquish</td>
<td>Attempting to accept one’s current situation. Related to the limits of one’s ability. Requires faith. Not easily accomplished.</td>
</tr>
<tr>
<td>Acceptance</td>
<td>An outcome. Enhanced by one’s understanding of a beneficent will of God and God’s omnipotence.</td>
</tr>
<tr>
<td>Control</td>
<td>Attributed to God and one’s endeavors. Control of actions was deemed possible due to God’s intervention. Decreases negative affect.</td>
</tr>
</tbody>
</table>
Intimacy of relationship. Respondents discussed the quality of their relationship using three primary representations: intimacy through presence, intimacy through knowledge, and intimacy through behavior. Regarding descriptors, the respondents provided insight into the nature of the relationship using several descriptions: personal, connected, all I have, very good, close, my everything, my all in all, buddy, caretaker, constant companion, child of God, partner in daily walk, subordinate (but also partner), creator, totally dependent, depend on each other, very personal, and trusting. Participants’ personification of God (e.g., daddy, mother, partner, husband, and friend) indicated an intimate relationship. One participant reported “My God, He’s my daddy, my heavenly daddy, and He would do everything He could do for me.” (White) Participants described their relationship as personal. One noted, “we believe that everyone has their own relationship with God. We believe that other people don’t tell us how to think, and God is with us every minute.” (White)

Intimacy through presence. The intimate quality of one’s relationship with God was further elucidated through one’s experience of God being present. Speaking of her relationship, one participant stated “It’s a daily thing, and I am one of His hardheaded children, but no matter what, He said he would be with me, and that makes me close to Him.” (AF AM) God’s presence was often experienced through a feeling. One noted:

It gives you a calm feeling, knowing that He’s there. He’s always there. They call it the Holy Spirit, but I just feel like it’s God himself. And I know that He must have angels helping, but to me, I feel like it’s always Him (voice quivering, becoming emotional). (White)

A respondent reported:

In the Song of Solomon, the poet is saying, ‘My lover comes like a gazelle bounding over the mountaintop and peeping through my lattice, to look upon me.’ Well, God is drawn to us during our joy and during our sorrow, not to interfere, but to be nearby…That’s the way God is with us. God is there. (White)
One noted experiencing God’s presence in the absence of their request: “I think He is there for us whether we have asked or anything. I think He’s there for us.” (White) Another reported presence in times of need: “I think it’s all your relationship with God that, you know, that He’s there for you and He seems to be with you in times of need.” (White)

Often, participants would discuss the importance of their relationship with God by discussing God being the “only one.” One reported “When problems arise you know that He’s the only one that can see you through it. You derive your strength in Him so therefore, your strength in Him becomes stronger.” (White) Another stated:

I just know I can call on Him all the time (laugh), I probably worry Him to death, but I feel closer because I have no one else, for one thing, and I depend on my faith to keep me. And it has never failed me yet, so I will continue to depend on my faith and I will pray for faith on a daily basis. (AF AM)

*Intimacy through knowledge.* The intimacy of the relationship described between person and God was further discussed in terms of God’s intimate knowledge of the respondent. Participants reported: “God knows you, knows your thinking, knows your actions and before they occur, knows your heart, knows your every need, and knew about us before we were born, among others.” (AF AM) One participant noted:

He knows what it is. He made us. He knows your ups. He knows your downs and everything. I think in the whole Bible, from Genesis to Revelation, there is no one perfect somebody that God used, you know. All of us have problems, all of us have some faults, all of us have infirmities. But, by the grace of God, you can live with ‘em. You can live with ‘em just like when I lost my mother. That left a scar on me that would never heal, and especially because my mother and I were real close. I haven’t gotten over it, but I’ve learned to live with it. By the grace of God, I’ve learned to live with it. And I found out He can fill the void left in your life, you know. He can be the best mother you ever had. (AF AM)

Here the respondent discussed God’s knowledge and a characteristic of their relationship (like a mother). Another participant reported:
He made me and I was just born again when I had sense enough to know that he was over me. But He tells me through the Bible that He knows me when I was in the womb. He knows every strand of hair on my head. So if He made me, who better to take care of me but Him? (AF AM)

This participant associated care taking ability to God’s knowledge while another associated it with trust, “God knows me better than I know myself, so I’ll trust Him.” (White) A respondent reflected on God’s presence and knowledge of her:

I don’t leave it at home. If I went on vacation, God would go with me. I don’t go in a closet thinking that He doesn’t see what I’m doing. There is no place God isn’t. He is always everywhere, omnipotent, omnipresent, there. (White)

One participant spoke regarding a connection and understanding so unique that only God could comprehend her communication: “Once I received my gift of speaking in tongues, I felt like I could never, ever go back on it, and I just feel so much closer to Him.” Regarding speaking in tongues, she states “In the Bible it says there’s a language that is only between you and God, and you and God only, and only God knows and understands.” (White) African Americans reported experiencing this form of intimacy with God to a greater degree.

*Intimacy through behavior.* Respondents perceived God’s behaviors and interactions as occurring within an intimate relationship and being expressions of intimacy. Behaviors included: God hears you, provides a feeling to let you know you’re being listened to, God’s taking care of me, He’s carried me, God’s looking over me, walking with me at all times, provides everything I need, He made us, God brought me through, and He meets you where you are. Regarding God listening, a participant reported:

You can talk to Him without even opening your mouth, even in your mind, in your heart. He knows that because He knows you. And when you call on His name, He’s gonna hear you, and when He hears you, He’s gonna know that is His child that’s calling on her Father, her Heavenly Father. Because when I call on Him and He hears me, I’m gonna know that He hears me because He’s gonna give me that feeling that He hears me. (AF AM)
As with a majority of aspects related to an intimate relationship with God, this participant reported a feeling that God provides something in relation to God’s listening. Another participant stated “He sees everything you do and He hears everything you say, even before you say it.” (AF AM) A respondent discussed aspects of intimate care provision:

If He knows you’re leaning on Him, He will see you through. He has seen me through so many…He has just carried my through so many, you know, ups and downs and I’m just knowing I’m not gonna make it. This may be hard, but it wasn’t hard at all because He knows I’m leaning on Him. I have that faith that I know He’s sitting out here looking over me. He don’t bat His eyes. That’s some looking isn’t it? That’s some seeing isn’t it? Never bats His eyes. That’s looking right through me, and He knows. (AF AM)

She noted God seeing her through, carrying her, and watching over her as well as God’s knowledge of her.

For many participants, having an intimate relationship with God was so important that they voiced a lack of confidence regarding being in its absence as well as confusion regarding those who do not also share such a relationship. One noted “God is my all in all. He’s the number one, and I just don’t think I can make it without Him, and I don’t understand how other people can. It is really hard.” (White) Another respondent reported:

I’ve know God since I’ve been here, in varying ways, I guess, and hopefully in fuller ways. I would think that kind of (laugh) describes my relationship. I can’t imagine there not being a God and not being close to Him. (White)

**Intimacy of relationship and church.** Participants’ experience regarding church’s association with an intimate relationship with God was variable. One respondent reported a reliance on personal relationship with God taking precedence over church: “I don’t know whether teachings of the church help me that much. Mine is a personal relationship with God.” (AF AM). Another participant reported a similar attitude:

I don’t have to have church to believe in what I believe in. I mean, I believe I need to be in church, but like I say, it’s just hard to find one, and I haven’t been a member – I mean, I’m a member of a church, but I haven’t been a regular person going to church in three or
four years, you know. But sometimes I think I’m closer to God than I was whenever I was going to church. (White)

Alternatively, a respondent reflected on the importance of church in relation to his relationship with God:

I used to have the idea that I could worship God – I grew up in the church, and I guess, like 95 percent of the people, I strayed away from the church, you know, and I got the idea that I could worship God at home as well as I could at church. And then, the more I studied His Word, just like He says in Hebrews, ‘Forsake not the assembly,’ you know. And then you get around Christians, your spirit … I think it’s like a cold: it could be contagious, and if I get with your, I might be feeling down in the dumps, but I can catch your spirit and that will lift me up. So I think God … you were created to have fellowship with Him, and your fellowship with God is through His people. (AF AM)

**Presence.** Exploration of respondents’ narratives revealed their experience with God’s presence taking two forms: physical presence and promissory presence (which denotes awareness that God is available). These two aspects were difficult to distinguish given the language that was used. Specifically, respondents often used similar terminology to discuss both aspects – primarily speaking in terms of God “being there” and being “with me.” Further complicating this division is the similar sequelae of presence. Both aspects of the presence of God was reported as providing a feeling of protection, calm, peace, comfort, assurance, confidence, and security. These aspects were also noted to make the participant aware of God’s presence (“God letting us know He’s there”).

**Presence of God and provision.** Regarding God’s presence and provision, one respondent stated “I think He just gives you the feeling to know that He’s there.” (White) Another stated sensing God being there and reflected on a sense of peace and understanding accompanying the presence:

It’s just like a peace. You have like – you just feel like you’re protected. There’s not a certain feeling, your body doesn’t feel any different, you just kinda feel like…you just know that everything’s going to be OK. You just have a peace of mind that everything’s going to be OK. (White)
One respondent discussed God’s presence providing peace in the face of adversity:

God said He’s gonna take care of you, I don’t care what. If the pain gets too hard, He’s gonna be there to help you bear it. He didn’t say this life journey was gonna be easy. Then I think… when you trust God you can have the worst pain the world and still smile. You can have the worst… all kind of stuff can happen to you and you can still smile because, you know, you can feel the presence of God. (AF AM)

Similarly, a participant stated:

I don’t really hear anything, but I feel at peace, and I feel whatever maybe I was talking to Him about, maybe it’s something I was troubled about, I feel comforted from it. So I feel like that’s His way of showing me that He’s there, He’s heard it. (White).

*Physical presence.* Participants held a belief that God’s presence is constant. One noted “God doesn’t leave me. God doesn’t walk away. He’s always there. I mean, that’s my relationship. That’s why it’s gotten deeper.” (White) Despite this belief, many participants’ experience of the salience of the presence of God was variable. In terms of physical presence, participants reported: “He’s there all the time, but He’s definitely there when you need Him the most.” When queried about “needing Him the most” she responded:

I need Him all the time, but it’s just maybe… maybe that’s when – it’s not that He’s there more whenever I need Him the most, maybe it’s because I notice it more whenever I’m in time of need. Maybe that’s what it is: I notice more that His presence is there. whenever I’m… like, you know, in illness and stuff, you can feel His presence more. (White)

With this participant the presence of God becomes increasingly salient in times of need.

Alternatively, a respondent discussed separation of presence in time of need; however, salience remained heightened. With this participant, a lack of feeling of God’s presence was a consequence of her actions rather that God’s:

God never pulls away from us, we pull away from Him, and sometimes we’ll be in circumstances or we’ll be in positions that we don’t feel His presence as strong, and it’s those times that then I have to say ‘Lord, I need to seek you, I need your presence, I need you to come closer, I need to come closer to you.’ You know, God’s presence is always there; it’s just that when we, as humans, need Him most, we feel separated from Him, but that’s a time that He wants us to pull that much closer to Him. (AF AM)
The variability in the experience and sensation of God’s presence was noted to be, in part, a factor of the nature of the relationship and was related to intimacy. Someone stated:

Have you ever been a child and you were hurt and you ran to your mother and she’d take you in her arms? That’s what, to me, the presence of God is. I was telling the people at work that sometimes you’ve just got to sit on God’s lap and just let Him hold you, and that’s to me, you know, His presence, I can just feel Him and feel His arms around me whenever things are not going right. I can hear Him whispering, ‘It’s going to be alright, I got this.’ (AF AM)

An aspect of African American participants’ experience with God’s presence involved a spiritual presence, discussed as the presence of the “Holy Ghost” and as God “dwelling inside you.” One participant stated “He gives you that feeling. He gives you that…it’s…oh Lord Jesus. It’s a feeling that can’t nobody else tell you or give you anything else. It’s in your heart. He deals with your heart. He dwells in your heart.” She went on to say “He gives me that born-again Christian feeling, that Holy Ghost feeling.” (AF AM) Another respondent stated “He dwells within, and when He speaks, He doesn’t speak to these ears, He speaks to your heart.” (AF AM) The experience of God’s presence appeared to come from within as opposed to being provided externally.

Furthermore, among African American participants the experience of God’s presence was associated with church in a manner not experienced by White respondents. One noted of God’s presence:

I feel it strongly all the time, especially when we gather at the church and we have praise service for Him. It’s hard for me to tell you – it’s just like… a personal feeling with God that I know He’s around me and I know He’s protecting me. It’s very hard for me to explain other than that. It’s just a feeling that I have. (AF AM)

*Promissory presence.* A promissory presence was discussed in similar terms as physical presence (e.g., “God being there”). Promissory presence is disparate in that participants
discussed this as God being available, “God is there for me,” and “God is on my side.” One participant stated:

I love Him and He loves me. I feel close to Him, like I’ve told you; with Him all things are possible. He didn’t promise a rose garden and things are going to be tough at times, but you know that He’s there and He’s going to give you strength to carry through. (White)

Another participant spoke of God’s availability: “I think whenever I have a special need, I have the feeling He is always available and always there, and I don’t feel bad about going to Him. It’s just … love that will not let me go.” (White) A respondent discussed God’s presence for her behalf: “He’s just there for you. You know, you have to have faith to know that God is not punishing you for growing older or having whatever’s wrong with you wrong with you.” (White)

Relationship as coping. This section describes the ways in which one’s relationship with God is integrated into coping with health issues. Many of the aspects previously discussed regarding one’s relationship with God are salient factors in the God-person relationship as a coping mechanism and represent the framework within which the subsequent experiences can be understood.

Communication to God. Given the high frequency and ubiquitous nature of participant discussion regarding communicating with God, communication represents the participants’ primary means of interacting with God. Both content and process of communication to God were explored and will be discussed.

Content of communication to God. Participants discussed their experience with communicating with God regarding four primary content areas: request (God will you please do X?), command (God, do X), inform (telling God about X), and acknowledgement (God, I know you already know about X).
Requests. Requests were discussed in several areas, with the majority targeting petition for the provision of the means to cope with health: ability to do what’s needed, strength, guidance, leadership, knowledge, mercy, care taking, help, patience, safety, protection, and acceptance. Generally, requests took the form of asking God for help, either directly or indirectly (e.g., provide something that will let me help myself). A respondent reported regarding requests for knowledge “My prayers have been enough for me, about my eye, to see what is best and right, and follow through and do what I can do to not lose my sight.” (White) Another reported on requests for help and a sign “I ask Him to help me and I ask Him to talk to me or send me a sign or something that I can understand.” (White). One requested help with mobility “When I say, ‘God, help me get across the yard and get going and everything,’ then I have confidence, so I just go. And it’s, you know, it’s a wonderful feeling knowing He’s really looking after you.” (White)

Requests for more direct intervention were discussed as well: healing, pain relief, God’s involvement, God’s control. A participant stated “When I ask God for anything, it’s usually, you know, for no pain, maybe to help me get through a day, give me strength, give me patience.” (White)

Participants reported requesting a sign of God’s presence:

I had a dizzy spell, it’s called vertigo, and… (laugh) I thought I was dying. I knew it wasn’t a heart attack; I’ve gone through that, I know what a heart attack is like. I couldn’t get up off the floor. I never lost consciousness, but I couldn’t get up. My legs wouldn’t hold me, the house was spinning, everything was spinning. So I just said, ‘God, I don’t want to die here alone like this,’ and I just started talking to God and everything started getting clearer; the more I talked, the clearer things would become. And then, when I finally stopped talking, I was able to get to the telephone. Then I didn’t know what to do with the telephone, but I said, you know, ‘Thank you, God, for bringing me through this.’ (AF AM)
Commands. Commands were discussed in multiple areas: help me, take care of this, handle this, solve this problem, show me, guide me, fix it, and rescue me, among others. One respondent reported “I will do what I can. I talk to the Lord: ‘You’ve got to handle this. I’m looking to you now to handle this.’” (AF AM) Another stated “What prayer is, you know, it’s sending up, you know, what I really, really feel. You know, sometimes you’re angry: ‘God, I’m hurting bad, you know. Do something. Come and rescue me.’” (AF AM) A participant noted:

I had the flu about two or three weeks ago. You know, I couldn’t get up and down, I couldn’t do nothing, but I had to – I mean, I was by myself and, you know, I just have to pray, ‘Help me get up, help me get to the bathroom, help me go get something to eat, something to drink. You’ve got to help me because I can’t do it myself. I am just too sick.’ And I think that’s the only reason I got through it. Because I got up to get something to eat, I got up to go to the bathroom. And, you know, since I am by myself, you know, He let me do it safely without getting hurt, because I couldn’t hardly walk. And, you know, it’s kind of hard when you’re by yourself and trying to cope with all of that. (White)

Inform. Communication to God frequently took the form of informing God about aspects of the respondents’ lives, including: the situation, their condition, health, their needs, needing God’s effort, needing help, being alone, the effort they have put forth, reaching the limits of their ability, lack of control, relinquishing, acceptance of God’s will, etc. A respondent reported “I talk to Him about it, you know, about my condition, but I know He knows all about it, so it’s nothing to talk to Him about it because He already knows.” (AF AM) The majority of communication in this domain involved informing God about reaching the limits of one’s ability and relinquishing the problem to God. A participant reported telling God about her perception of an inability to further cope with the situation, “I usually tell Him, ‘I’m giving it to you. I can’t handle it anymore, I can’t deal with it. I’m giving it to you to let you work it out for me.’” (White). Another participant discussed informing God about her efforts and limits. “That’s what
you have to do at all time. I’ve done what I could. When you say, ‘I’ve done what I could, Lord, and the rest is left with you,’ mean that.” (AF AM).

Acknowledgment. Participants discussed aspects of their communication to God involving acknowledging what God already knew. Areas acknowledged include: being in need, needing God, limits of ability, one’s efforts, assurance, faith, God’s presence, God’s knowledge of the situation, enjoyment of God’s presence, reliance on God, God’s omnipotence, God’s help, relinquish, God’s grace. One respondent acknowledged God’s care taking:

This past week has been a challenge for me, and constantly I'm telling Him that I rest in His care. ‘You’re taking care of me, Lord, and I'm just trying to rest in your care, in your loving arms, to support me and give me strength to do what I have to do.’ (AF AM)

Another reported:

I don’t have an answer, you have the answer, only you, and I'm just here depending on you. Whatever it is, Lord, just let me be accepting of it, whatever it is. I know it’s not my way, it’s your way. (AF AM)

Acknowledgement often preceded requests and/or commands: “God’s my heavenly father and, you know, it’s like talking to Him, it’s ‘Lord, you know what this is all about. If it’s your will, take it from me; if not, give me the strength to go through it.’” (AF AM) Another reported “God (laugh), I'm your child, you know all about me, so lead me and guide me, and where you lead me I will follow.” (AF AM) African American participants tended to engage in this form of communication, especially regarding recognition of God’s knowledge of them. This is associated with African American’s disparate experience of God-person intimacy. Additionally, this type of acknowledgement appeared to represent an affirmation of beliefs regarding God’s will or plan.

Process of communication to God. Participants’ communication to God was informal (e.g., “just talking,” conversational) and devotional (e.g., semi-scheduled, with the assistance of
books at times), with the former representing the vast majority of communication. Means of communicating included internal and external dialogue. Informal communication was often experienced as an aspect of one’s intimate relationship with God. One respondent stated:

When a situation arises, you just talk to Him, you talk to Him like you’re depending on Him, just like I’m sitting here talking to you. You ain’t got to go to Him in no formal fashion, because He understands the uh-huhs and the uh-uhs and everything. You haven’t got to be eloquent to talk to God. You can just meet God on your own terms because God will meet you where you’re at. (AF AM)

Regarding devotional prayer, someone reported “When I wake up in the morning, I have a . . . you can call it a routine if you want to. I get up and I have a devotion with Him, I have a prayer life that I pray with Him, and then I do some inspirational reading and I read my Bible.” (AF AM)

Communication to God is enhanced when in need. Respondents discussed the changing nature of their communication based on the situation. Communication frequency increased as well. One reported “Maybe the saying wouldn’t be much different but the feeling inside of me would be different. The feeling would be much more intense if the situation was more serious.” (White) As noted previously (in regards to presence), the nature of the interaction remains stable, but the salience increases with perceived situational intensity. Although experience with informal prayer was generally experienced as a means of assistance with coping, some reported praying in the absence of a need. One stated “A lot of times you just want to talk to God. You don’t have to have any specific need to pray for somebody or anything else, it’s just you want to talk to Him.” (White)

Communication from God. Participants’ experience of receiving communication from God came in the form of sensations, physical feelings, thoughts, nature, others, and the outcome of situations. Most communication from God is experienced as other-than-audible. One
participant stated: “He helps me by letting me know I’m getting tired, like saying, ‘This is too much, so don’t do any more.’ And I feel like He tells me that, letting me know in my head that I’m doing more than I should be doing, to stop, find something else.” She goes on to say “I think a lot of it is God is telling me by my physical feelings.” (White) Another respondent reflected on God’s communication through multiple methods, requiring vigilance:

You go into prayer about it and then you see what God has to say about it. And like I say, He’ll talk to you just like He might use a doctor to explain something. He might use someone who’s had the same problem, and you talk with them. So God uses different means to communicate with you. (AF AM)

Another respondent spoke regarding sensing missed communication due to a lack of attention:

I know He’s speaking to me all the time and I’m not paying attention (laugh), but I’m sure He speaks through other people and . . . just many ways, and I just ignore Him so much (laugh). I don’t follow through on half the things that I think would be a good thing to do, but some of ‘em I hope I do follow through on (laugh). He is continually, I think, telling me. (White)

Participants frequently discussed communication from God as being experienced as intuition or conscience. One noted:

Well, I’m in a lot of pain, I’ve been taking shots in my knee every two to three months, and one of my times when I was down and out and crying, didn’t know what to do, you know, He just speaks—well, He don’t literally speak to you. You are . . . you are . . . Find a word, [respondent’s name]. You are trying to figure out what to do and what would be best to do, and then all of a sudden you know what’s best to do, and that’s God talking to you. (White)

Another stated:

He shows me how to deal with it. If I’m losing it, He shows me how to—He tells me how to and He shows me through studying the Bible and my personal experience that if I need to rest, I need to rest. And God knows I need to rest. He’ll tell me, “It’s time to go to bed, [respondent’s name], before you lose it.” And He just—He’s like my conscience. And that’s not me, that’s somebody else talking to me, but . . . in my belief, it’s Him. (White)

God “answering prayers” was frequently discussed. Respondents reported God’s answers to request prayers being “yes” or “no” and noted the answer occurs in “God’s time.”

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Waiting on “God’s time” requires faith and a specific notion regarding the nature of God’s will and plan. Participants experience with these facets of their God relation and coping will be reported further in a subsequent section (see Faith and God’s Will).

**God provides.**

*Content of provision.* Given the pervasive nature of participants’ discussion of their experience with God’s provision, it is likely that it represents a primary means of God-person interaction. In terms of the content of provision, respondents discussed three main areas: mental/cognitive/knowledge-based, emotional, and physical.

**Mental/cognitive/knowledge-based provision from God.** Regarding mental/cognitive/knowledge-based, God provided knowledge to self, knowledge to others (doctors), guidance, direction, mindset, understanding, answers, revelation, prompting, input, perspective, and knowledge that it could be worse, among others. One participant reported:

I feel like God is guiding me to doctors, you know, that have helped me and for different reasons, you know, not just arthritis but different things that I feel like God has guided me to people that could help me with my ailments. (White)

Another reported:

But you go to God and then you work with—let God know about it and then God’s gonna give you guidance, He’s gonna give you directions and everything, how to go about it. You might think you’re doing it on your own, but it’s God working in your life. (AF AM)

African American participants experienced God’s provision of knowledge through the “mind” or alteration of their “mindset.” One participant reported “I just know that whatever I can’t do for myself, He’ll show me how. You know, not literally come down here and show me, but He’ll give me the thing in my mind, you know.” (AF AM) Another respondent reported:

Well, if you ask Him, He will give you a better—a correct mind. He will straighten out—the mind I have, I have to ask Him to guide my mind. I ask Him to guide my thoughts and guide my thinking. I do it all the time. It’s just something I do. I know I need Him to guide my thoughts. (AF AM)
A respondent stated “God has given you this mindset to think, to be able to take this pill or to take whatever this medication is to help your body or your illness.” (AF AM)

*Emotional provision from God.* Regarding the emotional realm, God provided satisfaction, peace, comfort, calm, freedom from worry, confidence, love, sense of wellness, strength, resolve, will, motivation, courage, security, encouragement, feeling the situation is being handled, etc. One participant stated “It’s comforting to know my rod and my staff, they comfort thee (laugh), and I find that to be true, so that helps me.” (White) One participant reflected on her experience with God’s provision of fortitude. Fortitude – and the like – was often provided as a consequence of participants’ perception that God does not allow one to be in a situation that they cannot cope with:

He ain’t about to let me give up yet, and He told me this ‘cause I had tried a lot of times (laugh). Oh, that’s not funny, [respondent’s name]. (Sound of respondent slapping her hand) God slapping me. No I’ve tried more than once, and He just basically told me, ‘You ain’t going yet.’ And you know what? I ain’t going yet. I don’t know if that makes any sense, but it’s not time for me to go yet. He . . . makes me recall, from the Bible, things that are in there, like He’ll never put more on me than I can handle, and that gives me resolve to man up or woman up and be strong. (White)

*Physical provision from God.* Regarding physical provision, God afforded provision to self: pain relief, healing, physical ability to accomplish a task, five senses. God also afforded provision of others and objects (i.e., doctors and medication). A participant noted God’s effect on his physical functioning:

He gave me the strength to get up this morning, He gave me the strength to make it through the day, you know. I’m not doing it on my own. I’m not doing it on my own. Because God gives you the use of your limbs, He gives you the activity of your limbs. (AF AM)

Speaking of pain relief, a respondent stated:

Well, I think He takes my pain away, some of it. It might not all be gone away, but I think it gets better. You know, I think I get better and, like I say, it could just be all in my
mind, but I feel like He’s helped me, you know, with some of my aches and pains. (White)

*Coping characteristics of provision.* Apart from content, respondents discussed their experience of the nature of God’s provision primarily in two ways: problem-oriented and emotion-oriented. Problem-oriented provision was reported in terms of God providing what is needed with an expectation that effort must be put forth to use it for coping. Aspects involved in this form of provision were knowledge, guidance, doctors, medications, physical ability to accomplish a task, etc. Participants noted its availability for their benefit and emphasized their part in using it. One participant reported:

> Like I was talking about my husband with the connective tissue disease. OK, he wanted to learn about it. He was not going to learn about it by being close to God or praying to God. He was not going to learn about connective tissue disease that way. Because God gave him a brain to use his brain to figure out how to do that. You know, our bodies are… are… we’re supposed to *use* it like it was designed for us to use. (White)

A respondent spoke regarding God’s provision of the knowledge needed to manage her health conditions and of her responsibility to use what had been provided:

> You know people say, ‘If you believe God’s gonna do it for you, you don’t need to go to the doctor,’ but that’s not true. You know, maybe that’s His way of getting you better: by giving that doctor the knowledge to do what he needs to do to make me better. I don’t believe everything slip off like magic: OK, He’s gonna make you better [finger snap]. I think He shows you these things to make you better, you know, He put that out here for me, all the information to make myself better, and if I don’t do it and take it, then that’s on me. You know, I know I’m a diabetic; if I go in there and eat all this stuff, and I get sick, that’s on me. Because He gave me the knowledge and everything to get better, and that’s how I think, you know, that’s how I think God does. (AF AM)

Another participant spoke regarding indirect provision of physicians and medication that allow her to maintain health: “I feel like that God has given the doctors the medication that I should have in order to be able to function, and I feel like each pill I take is something that’s come my way because of God.” (White)
Emotion-oriented provision involved those things that could not be used to fix a problem directly, but rather assist with engagement in further coping or with emotion coping. These things involved: acceptance, strength, etc. One participant reported on receiving the fortitude to endure. “Yes, He gives you strength. Like I say, He is gonna either move it or He’s gonna give you the strength to bear it.” (AF AM) Another stated:

I pray to Him. I pray to Him about my illness or whatever it is. I pray to Him and then if it’s His will, it’s gonna be healed. And if it’s not His will for it to be healed, it’s gonna be His will for me to be able to cope with the situation and whatever condition that I have. And if it’s not His will, then just be thankful that He allows you to be able to do what you do. (AF AM)

These two participants display the two ways in which God provides and make note of an oft cited perception related to God’s provision: God will provide to fix the problem and/or to fix the reaction to the problem. Notably, this phenomenon is related to God’s will, which appeared to make emotion-oriented provision more palatable (in light of not being able to fix the problem or God not fixing the problem). This will be discussed more in a subsequent section (see God’s Will).

Participants reported that often it was faith and belief in God that allowed emotion-oriented provision. A respondent spoke:

It’s been difficult, but you know, it’s that trust relationship. It comes down to complete trust. That’s the role He plays in my health and in my life and everything. As someone once said, ‘You can exhale, but the next breath is given by God.’ And it’s true. So when you realize that God gives you every breath . . . I’m just a real blessed person (laugh). (White)

Another participant stated:

The fact that I believe that anything happens to me, He’s gonna take care of it, and I believe because of my faith in God. That’s how I cope with it. I don’t worry about having to go to dialysis. And you know where it helps you best? It’s depression. Do you know everybody who ends up on dialysis, the doctors know they’re gonna be depressed and stuff. But you know what? I don’t let that get to me. I thank God and I pray to Him, ‘I know you’re gonna make me better,’ and I give and I start doing things. I
don’t let depression get me down. And I know it’s because of my faith in God that I just don’t get depressed. (AF AM)

The trust and intimacy of the God-person relationship instilled a sense that God will ultimately manage the situation or provide what is needed to manage, and that this provision assisted with continued emotion regulation.

Some African American respondents discussed their experience of provision as being more controlled by God. Respondents discussed this form of provision in terms of God “leading,” “taking over,” “controlling,” and receiving undeniable directives. One participant reported:

You can see Him working all the time. Because you go out there and you’re in one lane going down the road and then something says to you, ‘Get out of that lane,’ you know. And I won’t say ‘something’; the Holy Spirit says to you. And you wonder, Why am I changing lanes? I don’t need to be in that lane. But you go on and get in that lane, and on down the road, there’s this crazy person that, if you had been in that lane, would’ve hit you dead center. Then you say, ‘Thank you, Lord,’ because He’s looking out for you when you’re not looking out for yourself, when you don’t even know trouble is in your way. But He has a way. (AF AM)

This participant discussed her experience with following directions or directives without a clear a priori understanding of their purpose. This is similar to intuition discussed previously.

Reliance on God. Participants discussed a reliance on God, often reporting a dependency, stating “I can’t make it without God,” and noting behaviors such as lean on, depend on, and rely entirely on. Reliance was often discussed in terms of what they would not be able to accomplish without God.

Participants’ experiences with reliance varied by degree, with notable increases in dependency based on the presence of illnesses and functional impairments. Consequently, respondents reported difficulty with reliance in their absence as occurred during times of youth and good health. One participant stated:
Well, when you’re well and everything is going good and you’re on the mountaintop, it’s hard, you know, it’s not as easy to rely on the Lord. You know, you think you’re young and you’re healthy and everything’s going good. But then when you get in the valley, you have to look up. (White)

Another stated:

Well, like I said, when you’re really down, yes, I think that I find more time for Him, you know, for prayer and, you know, study. Whenever I’m the worst, maybe that’s when I lean on Him the most. And I think that maybe He gives us that . . . that we can . . . what we can do for ourselves, you know. He strengthens us as time goes by, and with our own efforts, but I do think that we need to do what we can and rely on Him. Course, I'm not saying that I just wait till the end, but each day that He strengthens me— I want to do, you know, what I can on my own, but I ask Him to strengthen me and help me to do what I need to do. (White)

One respondent reflected on variable need depending on situational severity: “The Lord helps you handle everything. I’m saying in my dealings I rely on the Lord, that doesn’t sound right, more in a serious situation that in a smaller situation.” (White)

*Know through experience that I need God’s help.* Respondents’ feeling of reliance was substantiated through prior experience needing God’s help. One participant stated:

He has led me and guided me from that day forward, up until this day. I lean on Him, and that was the beginning of it. And I’ve had so many revelations, you know, from God. So that’s why I learned to lean and depend on Him. (White)

This participant spoke regarding her history needing the relationship:

You know, I’ve got at least 40 years of total experience on why you need to have a relationship with God, you know. I’ve been in the dark, I’ve been in the forest, I know what that looks like, and that is not a good place. And at least now if I sit in the middle of the forest I know that I am not alone. (White)

Another respondent reflected on ways that her history has enhanced her reliance (concomitantly with faith in God):

Well, it’s not easy, because we like to think that we are self-sufficient and that we do things (laugh) that are good. But, I just know that I’m not (laugh). It’s too many times that have proved otherwise, I guess. But that’s a part of my upbringing and what I have learned about God, and have tried and found to be true, I guess, is by . . . the doing thereof, maybe, is how I have learned to trust Him’ (White)
Reliance requires faith and trust. Participants’ experience with relying on God was integrated into their trust/belief/faith in God and spoken of in terms of an intimate relationship.

A respondent stated:

I’ve had major surgery, but now before I go in there, I laughed at Him and I said, ‘Now Lord, I’m not even worried, because I know you’re in the room.’ And I said, ‘You’re in my heart, and I’m just relying on you.’ I said, ‘And I know everything’s gonna be all right because you’re watching. I don’t have to watch. I don’t have to watch and see if they’re doing this, that and the other. I don’t have to even be worried about it, because I’m leaning on you.’ And He knows that. (AF AM)

Reliance related to relinquishing and reaching one’s limits. Reliance was experienced as an integral factor; however, it was noted that while a reliance on God is necessary, it is not sufficient for health management. One participant spoke regarding reliance in combination with doing her part:

I speak to the Lord often about my physical things. I have a heart problem, and I have—you know, when you reach 85 and 86, you get to wearing out all the parts (laugh), and you just have to think about those things. But I just make health a part of my prayer concerns: that I can stay healthy and do what I’m supposed to do. I don’t think that God is a magician or a (laugh) . . . well, whatever. I don’t feel disappointed because I have a cataract (laugh); I know that comes with the territory. But I know that I can do all things through Him who strengthens me, so that’s what I depend on, go to Him for, and I am willing to and glad to know that it’s just . . . I’m not giving the orders (laugh) or whatever. I hope to . . . accept and use in a good way. (White)

Another participant reported on not just depending on God and engaging in behaviors herself:

Well, I don’t know that you could say I was being led by God, but that because I’m God’s creature, this is what I do. That I don’t just, say, depend on Him. I use what God gave me to figure out what I can do for myself. What I can’t do for myself, I accept. (White)

One participant discussed her responsibilities and simultaneously endorsed a total dependence on God:

I rely on Him to guide me and . . . I’m basically totally dependent on Him, you know. I have a part to do. I try to do the knowledgeable thing, the spiritual knowledgeable thing . . . to take care of myself. You know, this is His temple. (AF AM)
An aspect of some narratives included a perception that health problems were provided or allowed by God as a means of increasing person-God reliance. Regarding this issue, one participant reported:

And I guess that’s where Paul talks about the thorn in your flesh. Maybe it’s to keep us humble, to keep us—I mean, if you didn’t have any problems at all, would you really need God? Or if I didn’t have problems once in a while, would I keep my close relationship with God? Is that how He helps us to stay in tune with Him? Those are questions I can’t answer. (White)

Another respondent discussed a similar belief:

He said that’s what makes us stronger is our problems. You know, when we’re in the valley, we look up. And so God makes us stronger by—and I feel like maybe because of my illnesses or whatever disabilities that I have that I have become stronger, and I think that it’s a lot easier to neglect to call on Him when everything is really good, so maybe these things get our attention, you know. (White)

The experience of coping.

This section describes the components of a manner of coping that the respondents discussed with great frequency. These names are highly related and consequently, build on each other.

My part. Participants uniformly discussed aspects of coping with health and functional impairments that were their responsibility. Respondents’ engagement was experienced as physical and mental. Physical aspects of coping included: do the best I can, what I can when I can, what you can with God’s help, push yourself, just do it, do what you’ve been guided to do, pray, request wisdom and knowledge, seek knowledge and guidance, surrender, go to the doctor, follow the doctor’s directions, take medications, exercise, be healthy, and press on, among others. Mental aspects included: recognize limitations, believe in God, trust God, accept, don’t give up, be aware of what God wants, etc. One participant discussed several aspects of her responsibility describing both categories as she reflects on her experience with transitioning into
using a macrobiotic diet (i.e., primarily eating grains and vegetables while avoiding meat, processed and refined food):

My role is to do what I’ve been directed to do, and not get freaked out. My role is to not not trust. That’s my role. My role is to go about my daily life, to the best of my ability, doing what I’ve been guided to do, you know. I mean, I fully am aware that the direction I needed to go to was given to me before, I mean years before, the issue happened. And then when I started to think more about it, even before I had the diagnosis, it was very clear that was God was saying, ‘Remember I taught you. You learned these things before. You knew about these things, you’ve experienced these things, and now you need to pull your awareness and your education forward. You need to do this and do this now.’ And I mean, trust me, in the beginning, it was very difficult, because I was exceedingly strict and I became sick, really, really sick, sicker than I have ever been in my entire life as I stopped some of the medications that I was on. When you have to purge your toxins out of your body, you get really, really sick, and I just knew that God was holding on to me through that entire awful, ugly period. (White)

*If there’s something you can do, you need to do it.* Regarding responsibility with health management, respondents discussed a perception that one must do everything in their ability and be earnest in doing so. Reaching the limits of one’s ability was an important aspect of the person-God relationship when coping. A participant reflected on these points:

Respondent: You do all you can do, and then, when you keep hitting a brick wall, that’s when you say, ‘Lord, I’ve tried everything, I don’t know what to do, please work it out for me.’ And at this point I think that’s when it’s OK to just back away because . . . (laugh) I don’t know, you just know. You can’t sit in a corner and say, ‘Oh well, I’m not going to do anything, God will take care of it.’ No. You do what you can, and you do all you can, and then God will take care of it.

Interviewer: OK. So you have to do what you can first.

Respondent: Yes, first.

Interviewer: And then God will take over.

Respondent: With the strength and the knowledge that He has given you. You use that, you do what you can, and then when you can’t do any more, He’s the miracle worker. He takes care of all that bad stuff or good stuff, whatever the case may be, and He’ll work it out. (AF AM)

*Responsibility and its association with one’s relationship to God.* One’s responsibilities were associated with a relationship with God; participants expressed God’s expectations of their
efforts. One participant reported one of her responsibilities expected by God included recognizing her difficulty with ambulation:

I know that I have some limitations, and I have to recognize what they are. He finds me parking spaces, so I don’t have to walk as far, but I’m expected to wear a decent pair of shoes and to be careful driving. And I don’t really go anywhere after dark. My garage is separated, and it’s a good walk, and my yard is not even, so I have to realize that I have some limitations. (White)

Another stated “He wants us to lean on Him, but at the same time, He wants us to do what we can for ourselves, with His help.” (White) A participant spoke of God’s expectations: “I’m willing to do my part. I’m always ready to find out what’s new, what’s going on, what’s best. I think that’s what He expects of me.” (White)

Use what God has provided. A participant discussed her belief that God wants us to use what has been provided, and noted that provision can occur in multiple ways:

Listen to what He tells you, you know? You do what your doctor tells you to do. You don’t say, ‘Well, God’s gonna take care of it.’ You do what he tells you, what the doctor tells you, ‘cause how do you know God ain’t taking care of it by giving that doctor the knowledge and by having him tell you what to do. You can’t just sit down and say, ‘Oh, He’s gonna bring it down here and drop it in my lap and put the medicine in my mouth’ and stuff like that. You can’t do that. You have to follow His direction. Everything on this earth, God put it here for us and for our use in the right way, and we do it in the right way. (AF AM)

Do your part and have faith that God will do His. Participants discussed the association between being diligent with health management responsibilities, having faith that God is intervening through those actions, and that God will continue to do so. In essence, the process of health coping involves both parties (person and God) while the outcome involves the latter:

You’re doing your part, and leave the results up to God. God has never asked anyone for results; He just asks for faithfulness, and you be faithful in your part.’… But see, a lot of times we want to do our part and do God’s part, too…So you’re gonna just have to believe that God is working through your medicine, He is working through your health physician and everything. You’re gonna just have to believe it and you’re gonna just have to do your part. Don’t let the doctor give you no medicine and then you’re just sitting up on the chair, you know. You’re gonna have to believe that the doctor knows
what he’s doing and everything, and you’re just gonna have to take control of that and believe that—look for God to give you results from it. (AF AM)

**What not to do.** Participants also spoke of their responsibility in terms of what they should not do: do nothing, overdo it, unhealthy things, disregard doctors, give up, disregard what God has provided, use God as a last resort, expect God to fix our problem without our effort. An emphasis was placed on doing *something*. One participant reported:

I don’t feel that you can totally, you know, not do anything. It’s like the Bible says: ‘Ask and you shall receive, seek and ye shall find, and knock and it’ll be opened unto you.’ So, you’ve got to do something and not expect God to do it all. Even though He could do it all, still, you have to be able to, you know, you have to do things yourself. (White)

A respondent reflected on her beliefs involving taking committed action, no matter the extent of her impairment:

I’m responsible because of who God is. Now, if I get to where that I couldn’t do the water therapy or if I couldn’t do anything except be bedridden, I would still feel like that I should do everything I could to make my life as good, what I could do, and not just say, ‘OK, God, you just take over.’ I don’t believe like that. But I believe that God would be there strengthening me to make the right decision. (White)

One participant discussed her belief that something must be done (whether it is active or not):

“You always do something, even if it’s just believe or pray. You can’t not do anything. You’re gonna have to do something.” (White). The manner that this participant discussed belief and prayer (“even if it’s just believe”) suggests that belief and prayer are foundational aspects of responsibility experienced as necessary, but not sufficient.

**God’s will.** Respondents discussed their experience with God’s will typically in terms of the plan that God has for the future. One participant discussed God’s will in terms of a path:

If I didn’t have the faith that I have and the intellect that I have, I think I’d have fallen apart a long time ago, gone into my house or whatever, and just vegetated. It would be so easy to give up and become wheelchair-bound and do nothing. But I am following a path that I think God would want me to follow, as a human being, as a person, and as a humanitarian. And with the health problems, they just are. I’m still following that path. (White)
Participants’ understanding of the nature of God’s will was unclear as to its specific content; however, they reported clarity involving God’s will being purposeful, reasoned, and for one’s benefit. One participant stated:

God gives me the feeling of unhelplessness. With God all things are possible. With man they’re not, but with God all things are. Mark 10:27 states that. So it’s like, that’s what gives me that strength, that non feeling of helplessness … I know He’s not out for my ungood. Jeremiah 29:11 states that He knows us and He wants the best for us, you know. He has plans for us, you know. So it’s like, I’m not . . . I’m not worried. And to a good end, so I’m not worried about it. He wants the best for us. (White)

Another respondent reported regarding the goodness of God’s will:

Well, His plan is that He wants us all to be saved, He wants us all to be healed. [and] He wants us all to have a good life. And so His plan is that God is a good God, He’s good all the time. We’ve got to believe, again, that He is a good God, that He does want us to do that, and . . . His plan is a perfect plan for us. We don’t have a perfect plan for ourselves. So if it is His plan, then we’ve got to believe it. (White)

*Not more than I can bear.* Furthermore, participants discussed their belief that God’s will does not include situations that are intolerable or “more that I bear.” One participant stated: “I just gotta believe there is a reason and that God don’t give me anything that I can’t handle. And there is a reason, so I just keep going.”(White) One respondent discussed his experience with having faith that God would alter the situation in such a way that it is tolerable (either through problem- or emotion-oriented provision):

I hurt, but I thank God for the pill that eases the pain. I’ve always said that, when I get down like that or I get heavily burdened or body wracked with pain and everything, God is gonna do one of two things: he’s either gonna move it or He’s gonna give me the strength to bear it. And that’s the kinda faith I have in Him. (AF AM)

*Indeterminate nature of God’s will.* Respondents reported that God’s will is not always clear or interpretable; however, by the nature of it being God’s will, it is tolerable. This requires faith that God’s will is good. A respondent stated:
He has a purpose for everything that He does. We may not understand it, and a lot of things we don’t understand, you know, but we accept it by faith, by faith. We trust that God knows what He’s doing. He is the creator, He is the sustainer. You just accept Him through faith. (AF AM)

Participants also discussed their lack of understanding regarding God’s will in terms of not being privy to all of the information or “seeing the big picture.” This is related to one’s faith and acceptance of situations.

One’s situation being in discord with one’s prayer request (either in content or timing) was discussed as being consistent with God’s plan; because God’s plan was perceived as innately good and purposeful, the outcome was acceptable (i.e., It’s not what I wanted, but it must be what God wanted for me, so it’s OK). A participant discussed his experience with this:

A lot of people say that just because God don’t answer your prayer the way that you expected Him to do or that you would like for Him to do, you say that your prayers haven’t been answered. But you’re gonna just have to take it to the Lord and leave it with Him, leave it with Him and let Him work it out. He knows what’s best. We can’t see into the future. We don’t know what He holds in store. But I don’t worry about the future because I know God is already there. (AF AM)

Some White participants spoke about God’s will as being indeterminate. God’s will remains the same, but one’s actions can be discrepant with such and the outcome will not be what was planned for that person. One participant reported:

I don’t necessarily believe that things that happen are always God’s will. I know there are a lot of environmental influences out there that . . . that cause health problems. We don’t eat the right thing, we don’t—and that’s another thing, see. I try to eat right…I know that our weight and what we eat and environmental things, all of those things can affect health problems. (White)

Another participant discussed her experience with “getting out of God’s will” by not seeking God’s guidance and not following direction:

It’s like, why would I get liver cancer? I don’t drink, I don’t smoke. The one thing I did do—I used to weigh 430 pounds and I did have an operation a long time ago—I had it reversed—to lose weight. And one of the doctors that I saw said—now they know, you know, 20, 30 years later—that this is something that is a byproduct of the surgery I had.
And I said, ‘Oh really?’ But see, when I had the surgery, I was out of the will of God because I never asked Him to do it. People were pressuring me to do it and thought it was OK to do. I went in to the surgery a completely healthy person, completely healthy fat person. I weighed close to 400 pounds. I left that surgery with diabetes. I got diabetes after—I had it reversed; within the first year after it, I had . . . well I had atrial fibr and diabetes and terrible joint pain. So, um . . . you know, I look at that and that was my own fault. So I can’t say, ‘Why, God, did it happen to me? I made the actions. I got out of your will, completely didn’t even ask you.’ (White)

If one acts in discord with God’s will, an adverse outcome becomes the responsibility of the person.

**God’s time.** Respondents discussed the phenomenon of experiencing God’s time as an extension of God’s will. One participant reported on God’s time: “Just give it to Him and just leave it there and forget about it, because He’ll deal with it in His own time, because He’s a time god; he do things in His own time. You can’t rush Him.” (AF AM) God’s time was indeterminable and had the effect of leading the participant to question whether their current situation was due to God’s plan having yet occurred. One participant reported:

Well, you know, I went through a period of time whenever I was having so much problems with my joints, and my feet and my knees, and it was just hard to get up and come to work every day. And I prayed, ‘Lord, help me,’ and there was just . . . a period of time whenever it was just hard. I mean, it was like He wasn’t answering me, He wasn’t there. But then, eventually, I got better, so . . . I think it has to be in His time, not my time. (White)

God’s time was discussed when one’s request had not been met or when there was a discrepancy between what the respondent wanted and what was currently happening. A participant stated:

Now like in the morning, sometimes I get up and I don’t feel too good, and I know I’ve got things that day I’ve got to do, and I just ask Him to help me make it through the day and, you know, to ease my pain, and if He wants to heal me, He’ll heal me, in His time, not mine. I ask for healing, but I know to us, a year may be two seconds to Him. So I just be patient because I know the time will come, He’ll either heal me or just help with my pain. (White)
**Faith.** Participant experience with faith was discussed in terms of knowing and being assured that God can (“He is omnipotent”) and that God will act on their behalf. One participant reported:

No matter what pops up, He’s gonna get me there. Might have to make some detours. Didn’t say He was gonna take me straight there, but He’s gonna protect me. I may have to detour left or detour right, but He’s gonna get me there, He’s gonna get me there safe. (AF AM)

Another participant reflected on her experience being assured that God would assist her with managing cancer:

You have to strive, press on, you have to press on. Back in 1980, when I had the first battle I had with cancer, my kids were like . . . my youngest was two and he was six, and I was really fearful. I was fearful and I was scared. But then I looked at them and knew that they were going to be always depending on their mom, so I had to go and try. I talked to God and I just kept looking at them, you know, knowing that He would help me. And I did, I have, up until this point. Next month I'll be 62. (AF AM)

Trust was a salient aspect of faith. Participants often spoke of needing to trust that God would engage in some activity. One participant reported:

God works things. He puts people where they need to be when you need them to be there, and it don’t just happen, you know. The Holy Spirit, it’s all in trusting God, trusting that He will do what He said He would do. (AF AM)

*Faith and God’s will and God’s time.* Faith represented a salient aspect of narratives discussing God’s will and God’s time. One participant reflected on trust and faith in God while waiting on God’s will and God’s time:

Respondent: So we’re gonna have to learn to be patient, wait on God. A lot of times we want to run ahead of God, you know, and we want to use God for a Santa Claus god when we want something. We live in a world right now we want it right then and everything, but we’re gonna just have to wait on God. I mean, this is where faith comes in; this is where faith plays a part.

Interviewer: OK. Tell me about that, where faith plays a part. How does faith play a part?

Respondent: Because . . . as the Bible says, you that goes to God must first believe that He is God and that He is a reward of those that diligently seek Him. So when you go to God in faith—you’ve got to have faith. Without faith, it’s impossible to please Him. But when you go to God, you’re gonna have to . . . it’s something you’ve got to believe it and
receive it. If you ask God for something, you just have to wait, believing that He will answer your prayer and He will hear your prayer. And He says in His Word that anything that you ask in my name that the Father will give it to you. So you’re gonna just have to be patient, you’re gonna have to wait on God and trust in Him. (AF AM)

Faith and intimacy. The intimacy of one’s relationship with God as well as one’s past experience with God were noted to assist with one’s faith. A respondent discussed the intimacy of her relationship with God, the security that stems from the intimacy, and the trust and faith that results:

I just feel immensely loved by Him. So the role that He has for me is that it’s not like, um . . . I don’t know, He just gives me security. Because of my relationship with Him, I’m not afraid of the future, I’m not afraid of . . . as I said, I’m not afraid of dying. There’s no guarantee that the cancer will go away, there’s no guarantee that I’ll get better. But that’s not . . . I almost want to say that’s not important. It’s the security, that’s the role. It’s I trust, that’s the role. That’s the role He has with me. It’s the relationship of trust. (White)

Participants discussed faith as an activating agent for engagement in one’s responsibilities. This participant reported:

I have the role of listening and not to let the negativity get into me that causes the fear. So, you know, I have the role of accepting it and believing it and acting on it. Not just accept it but acting on it, and that’s where I think the faith comes in. You act on it in faith that God’s going to do what He’s going to do. (AF AM)

White participants discussed their faith with more questioning, uncertainty, and with discomfort stemming from not fully understanding. Speaking of Stephen Hawking (a theoretical physicist), one participant noted her transient experience with a lack of certainty of God’s existence:

After all of his grand study and all, has flatly come out there is no God (laugh). I feel so sorry for him and pray for him as I pray for myself. And, of course, you know, there are always thoughts that sneak in, Well, you know, how do you know there’s a God? (laugh). (White)

Additionally, one participant discussed questioning one’s faith secondary to painful emotional experiences related to organized religious personnel and activity:
I had gotten hurt so bad that I was just—I wanted to believe in God, but at the same time, I thought, you know . . . you get to the point sometimes you want to believe and you know that there’s a God and this and that, but then when you get hurt so bad and . . . I had issues in my life, like that I had found out that my children had been molested while I was out doing God’s work, and I thought: *Why did He allow it?* That was one of the issues. And then there was this preacher that was there at that time, and he did some things that really hurt us, and then we had a youth leader that was trying to take advantage of my child. You know, you just—when things like that happen, it’s hard to . . . keep your faith in God. I mean, it really is. (White)

**Relinquish.** Participants discussed a phenomenon of relinquishing. Terms used to describe this activity included: turn it over, turn over, let it go, leave it alone, let God take care of it, turned it up to God, put it in God’s hands, take things to God, leave it up to God, leave it at the altar, and leave it with God, among others. Many of these terms were elicited independent of narrative data collected during cognitive interviewing.

The process of relinquishing was typically accomplished through communication to God:

> You just tell Him that you’re giving it over to Him, you’re going to let Him deal with it, let Him take care of it. I usually tell Him, ‘I’m giving it to you. I can’t handle it anymore, I can’t deal with it. I’m giving it to you to let you work it out for me. If you can work it out for me, OK; if you can’t, then OK.’ But sometimes, you know, according to what it is, I can’t seem to totally feel like I totally give it to God, because if I did, then I wouldn’t be worried about it. (White)

**Relinquishing is preceded by reaching the limits of one’s ability.** Furthermore, relinquishing was often preceded by engagement in one’s responsibilities, reaching a limit regarding further perceived available options, and informing God about these events. One participant reported:

> Either God will take care of you—it’s almost like with this knee right here: I’ve done all I could do for as long as I could do it, for 27 years, and the worst of it was the last six years, and I’ve done all I can do, so it’s in God’s hands now and I’m gonna have the surgery. (White)

Another respondent stated:

> I usually pray about it and tell Him, ‘You know, God, I can’t handle it anymore; you’ve just got to take it and do what you feel like is right,’ and I just walk away from the
problem, you know, and just forget about it and let it just come about, you know.” (AF AM)

A respondent reflected on the limits of her ability:

Well, when you come to that point that you feel like you’ve exhausted all your options, it’s time then to turn it over to Him. You know, I feel like He’s with me all the time, but then when I’ve exhausted all my efforts, you know, I say, ‘Just take control and help me to accept.’ You know, I would like for my eyes to be back like they were before I had this problem, but I turned over it to the Lord. You know, I said, ‘The medicine’s done it, and it’s up to you, Lord, how my eyes are gonna be and how this arthritis is gonna affect my body. I’ve done exhausted . . . I’ve taken the medicine, I take the medicine, I’ve done everything that I know to do, and so it’s in your hands now.’ (White)

What is being relinquished? Participants discussed the nature of what they were relinquishing. Narratives in this regard involved relinquishing the outcome of a situation or one’s discomfort with being in the situation. One participant stated “I know it’s in His hands all along it’s in His hands but I took myself out of the equation.” (White) By taking herself out of the equation, this participant was indicating that her attempts to further alter the situation had ceased (in that moment) and that whatever happened would be the result of God’s will as opposed to her continued efforts. Another participant similarly discussed relinquishing the outcome:

You don’t know what God’s decision is going to be, and you cannot ask Him to do something that He doesn’t intend to do. You have to leave the choice up to Him, because He already knows what’s gonna occur.” (White)

Relinquishing the outcome of the situation appears to be more palatable if one perceived that they had reached the limits of their ability to further alter the situation.

Relinquishing requires faith. Relinquishing was discussed in association with worry and faith. A participant reported:

Just give it to God, let God handle it, and forget it. Which is, you know, when you’re worried about something, you can give it to God but you’ve got to have enough faith He’s gonna do it to where you don’t worry about it anymore. (White)
Furthermore, participants spoke about not worrying as an indication that one’s faith in God was strong:

And then once you say, ‘I’m gonna give it all to Jesus,’ if you keep thinking it’s not gonna get better, then your faith is weak, you don’t believe what you said. I learned that when I was sick. And after I decided that I was just gonna turn it over everything started to get better. They sent me to Birmingham and everywhere. And even my doctor told me, after I had gone walking in there and everything, Dr. ____ said, ‘You know what?’ He had a picture of me when I was really so bad, and he showed it to me, and he go, ‘Look what you looked like, and look at you now’ (laugh). I think my faith did it, I really do. (AF AM)

Participants discussed a phenomenon of limited relinquishing, during which time they would ‘turn it over then take it back.’ Limited relinquishing was associated with lack of belief in God’s plan and God’s time (God’s not working fast enough) and a consequential re-engagement in attempts to change the situation or to continue without God’s assistance. A participant reflected:

Now I must admit, probably earlier in my life, you know how you give things to God and you take ‘em back because, you know, ‘God, you’re not working fast enough here, I think I can do this on my own.’ But that doesn’t work. And the answer’s not always yes, either, and that’s what we have to accept, that sometimes the answer is no. And again you have to say, ‘Well, God knows best.’ (AF AM)

Relinquishing is not easily accomplished. Relinquishing was experienced as difficult. Specifically, respondents discussed problems with “leaving it there,” “not going back to it,” and “not taking it back.” This was related to a perception of limited trust in God or impatience with “waiting on God’s time.” One respondent reported:

Respondent: Sometimes, you know, when there’s something really big, and you keep going back and back and back to it, I think, Are you trusting? (laugh). But if it’s a concern to me, I think it’s a concern to God. I think that that’s kind of how I have taken care of that.
Interviewer: OK. So you said if it’s something really big, you keep going back to it.
Respondent: Yeah. The bigger it is, the more you go back, probably (laugh).
Interviewer: And so you question yourself: Am I trusting God?
Respondent: Yeah, right.
Interviewer: So, for big things, it’s harder to give up—is that what you’re saying?
Respondent: I would think. I’ve not had many, you know, big, big thing, I guess, but that’s kind of the case, I guess, yeah. And saying and doing is always a little discrepancy (laugh). I know what I want to do. I want to trust Him completely and not have that on my mind and not worry, but it comes back again. So that’s just showing how incomplete I am, I guess.

Interviewer: And so would you say that if you give your worries up, then you don’t think about it anymore?
Respondent: Um, I think ideally that probably would be it—you just wouldn’t worry anymore—but you worry . . . and maybe . . . I don’t know, maybe that’s the human condition. (White)

One’s perception of insufficient trust and associated limited relinquishing was often spoken of as being an aspect of flawed human nature and of an emphasis on self-sufficiency.

The need to further manipulate the situation to one’s liking caused re-examination of potential action; however, participants’ experience with reaching the limits of their ability was helpful in this regard:

Respondent: Because we are human. Human nature. I can do it, you know. We’ll go ask the pastor. We’ll go ask the psychiatrist. We’ll go ask the lawyer. We bypass God all the while. Go to God and give it to Him, and then he’s gonna send you to the person you need to go to.

Interviewer: OK. So you said you have to really mean it. [reported previously]
Respondent: Yeah. It is so hard to do because we, as humans, like to control everything. We, as humans, we want to control everything. And see, you have to make up your mind. I always use to hear my mother say, ‘I got a made-up mind.’ You have to make up your mind that ‘I can’t do this, and there’s no need me trying, so I’m gonna give it to God.’ And every time you start thinking of something, say, ‘Lord, it’s yours. I’m waiting on you, Lord.’ Because it’s gonna keep coming into your mind to do this or should I do this or should I do that. ‘No, I’m not gonna do anything. I’m gonna give it to you, Lord, and I’m gonna wait for you.’ (AF AM)

Another participant discussed her experience with limited relinquishing:

Respondent: I'll say, ‘Lord, you work it out,’ then I go home and get quiet and then I start trying to figure it out (laugh). Then it’ll come to me: You gave it to the Lord, let Him work it. No, no, there’s still more I can do (laugh). I’m arguing with myself. But I’m getting better with that because I know that there are certain things I just can’t do. So He’s working on me with that one.

Interviewer: So it’s hard to put something in God’s hands and then leave it there. [“putting something in God’s hands” noted previously]
Respondent: And just leave it. Yeah, it is, it’s hard. I'm not going to tell you it's easy, because it’s not. You know, as long as there’s breath in my body, I'm still trying to figure
out, did I do enough? Could I have done more? Is there something else I can do? Why shouldn’t I do this? Why can’t I do that? But, if you bump your head enough times, you’ll know only God can fix certain things. (AF AM)

With this respondent, previous adverse consequences assisted her in knowing the limits of her ability and sustaining full relinquishing. A struggle recognizing and accepting one’s perceived restraints represented a salient aspect of relinquishing.

**Timing of relinquishing.** Participants reported variable timing regarding when in the health coping process it was appropriate to relinquish the problem to God. A participant discussed relinquishing post engagement in activity that was assisted by God:

> I ask God first for the wisdom and knowledge, and then I do what I can, and then I put it in His hands, and then I thank Him for it. So it’s not like, I do what I can and then I give it to Him. To me, He’s with me all the time. I don’t put Him up on a shelf and take Him down when I need Him. (White)

For her, God was assisting throughout the process; however, relinquishing represented an acute event. Relinquishing pre-activity engagement is unique in that is not dependent on reaching one’s perceived limits. As noted previously, relinquishing was reported to be more palatable if one perceived further actions as constrained. A participant noted perceptions of failure in the absence of relinquishing a situation to God initially. For her, one’s ability is limited innately in the absence of God and a need to experience one’s limits is unnecessary:

> I turn the situation over to God and with God I’ll do the best I can do. But I don’t work it out before God has got a chance to... you know. He’s already got it under control. I’m just going, ‘OK, just guide me and tell me where I need to go.’ A lot of people seek God last, after they fail. Why not seek God first? (White)

One respondent posited that relinquishing first is ideal, but noted that it often occurs post activity:

> You’re supposed to turn it over to Him in the beginning, if you have a situation. It’s just like going to the doctor: if you have a headache, you’ve taken pills, aspirins, whatever, trying to get rid of it and then you go to the doctor. Well that’s the same situation sometimes with God: when you have your illness and you’ve done all you can, then you
decide to turn it over to Him. But you’re supposed to do it before then; once it happens, you go turn it over to God. (AF AM)

**Acceptance.** Participants discussed their experience with acceptance in relation to illness and functional impairments. Regarding the target of acceptance, participants reported: health conditions, that God is in control, that God’s Will will be done, that God has a purpose, that you are not in control, God’s plan, the outcome of health situations, outcome of prayer request, etc.

**God helps with acceptance.** Respondents discussed acceptance in relation to faith, trust, and God’s will. Specifically, participants reported that their knowledge that the nature of their experience is part of God’s plan assisted them with accepting and with their experience of illness, pain, or impairment. Having the belief that one’s experience is part of God’s plan requires trust. A participant discussed her experience accepting her disability because she perceives it to be part of God’s will:

Respondent: Well it’s just . . . petition, and it’s not always God’s answer is always my answer, but I'm accepting of it, and especially with this disability I have.

Interviewer: OK, so tell me more about that. You said God’s answer is not always your answer, but you are accepting of it, especially with the disability you have.

Respondent: Well, I just never thought I would be totally disabled, which isn’t totally, but I am immobilized. That just never seemed to be in my plan, but for some reason, it’s in God’s plan for me. So, that’s why I'm accepting of it.

Interviewer: OK. So you said it’s in God’s plan that you are currently disabled, and that’s why you’re accepting of it. What is it about that that leads you to be accepting of it?

Respondent: Well, because I know that everything that He does is His will. I was even told one time, you know, why I would move to a place like this. And of course I never dreamed in my wildest dreams that my husband would die before I did, but when it happened, I know there’s a reason, and I had friends tell me that there must be a reason I'm here, that I have His will to guide me and to help other people, and I do that. Because of my disability, I can’t attend church, but all my life I’ve been in church every Sunday and have worked in church just from the youth on up and, as I said, have taught Bible to adults for 50 years. So in that length of time I’ve certainly learned what God’s will is, and to be accepting of it is one of the things that’s difficult. (White)

As noted previously, having the belief that one’s experience is part of God’s plan requires trust. Having this trust was described as assisting with acceptance. A participant reported:
He just protects me. Even when things are happening, I feel His protection. And I know that doesn’t make a lot of sense to a lot of people. How can you feel protected by God and be having all these things happen to you? I think it’s very difficult to explain if you’ve never lived it, if you’ve never really trusted somebody that has not ever let you down. And God doesn’t ever let you down, so it’s easier to accept the things that go on in your life. (White)

Participants discussed discomfort and its acceptance through acknowledgement of it being a part of life and a part of God’s will and plan. Participants spoke of this in terms of “God didn’t promise a rose garden.” One participant reported regarding acceptance:

It means that, you know, I’m not a piece of wood that can only have wear and tear if someone misuses it like scratching, like I’m looking at that scratch on that chair. I have this wonderful machine in me that… because I was born into sin, I’m looking for my health to deteriorate. The older we get, your organs and things change. You know this is going to happen. He said once a man and twice a child. Then you know something is going to happen. So my health is not going to be always good. But as long as I know He’s with me, I can go through that. (AF AM).

Acceptance sequelae. Some participants spoke regarding the emotional sequelae of acceptance or lack thereof. One respondent reported positive emotion and a lack of rumination (dwelling) stemming from a sense of acceptance that her situation is part of God’s plan:

He has the ability to make you at ease with what happened to you, if it’s His will. He makes it all right with you. He makes you feel where, OK, this is my role in life, and I can accept it. You know, I can be happy at all times with my faith in God. I put it like that. And if that’s what He wants to happen to me, I can be happy with it and go on and let it go. You know, don’t dwell on it or anything like that. You know, when you get upset about something and dwell on the thing, it makes it worse. But when you can just let it go, it makes it better. And with God, I can just let it go. (1207)

Speaking of acceptance, this participant reported on her perception of consequences of not being able to accept a disability:

Well, it’s not easy. My eyes, you know, I started having trouble with my eyes before I found out I had rheumatoid arthritis, and it was hard to accept it, you know. You think If I were to go blind, how would I deal with it, how would my family deal with it, and what would I miss in life and how would I be active? You know? And then when this arthritis came along, I again felt the same way. I felt like that I would be very handicapped if it overcame my body. I'm very thankful that hasn't so far, you know, but it’s hard to accept. And without the Lord, you couldn’t, I don’t believe. I think it would really
damage you mentally. But so far, I feel very good about it and I’ve been able to accept it, but it’s not easy. (White)

Whole process. The following portion of narrative describes well the aggregation of themes that have been discussed heretofore:

Respondent: I’m totally dependent on God, and like I say, a lot of things I can’t explain but I accept it by faith, you know, and I say, ‘This is God’s will for my life.’ I just turn my problems over to Him. A lot of people, just like the song says, you take your burdens to the Lord and leave ‘em there. They’ll go to their altar and they’ll cry their heart out and then when they turn around, they bring their burden right back with ‘em. A lot of us, we think that God is not big enough to handle our problems, or think that He needs our part, He needs our help in it. But just turn it over to the Lord and forget about it. He said, ‘I’ve come that you might have life and have it more abundant.’ Enjoy this abundant life He has left for you and let Him take care of it. Once you give it to God, let God handle it.

Interviewer: Tell me about that, turning it over to God.

Respondent: That’s right. You just turn it over to Him. And I’m not gonna say—just like my emphysema, my breathing. I’m not gonna say that . . . I’m not gonna say that I prayed to God about it and then I just forget I got emphysema. I can’t do that, because my breathing is such a part of me, because that’s the humanity part of me. But I believe that God is gonna give me the patience to cope with it, He’s gonna let me live with it, and He’s working it out and He’s gonna work it out in His own time, even if He has to . . . See, a lot of people look at it . . . they look at it only on this side. But I got the faith to believe that when God calls me out of this world, I’ve got a home with Him. He’s working it out for me, so I’m gonna just . . . I’m gonna just let Him handle it, you know (laugh). If I’ve got emphysema, this is His will for my life. And I don’t sit around and mope, ‘Oh I got emphysema and everything.’ I’m gonna try to live the best, I’m gonna try to live my life to the fullest. (AF AM)

This participant reported a reliance on God and a faith that God’s will is being enacted. The participant discussed a faith that God would handle his health condition in a manner concordant with a purposeful will – even if it involved the participant’s death. Furthermore, the participant had faith that God would do this in accordance with God’s timeline (to which the participant did not have access) and that God would provide emotion-focused provision to assist with emotion regulation in the meantime. The participant’s reliance, faith in God’s will, and faith in God’s time allowed the participant to relinquish the intolerability of the situation and attempts to change the situation to conform to his liking. As a consequence, he was able to
accept his experience of illness and do so in a convincing manner so that he did not ruminate, worry, or attempt to alter an unalterable condition while simultaneously taking responsibility for “living life to the fullest.”

**Control.** Participants discussed their experience with control when coping with illness and functional impairments. They reported two seemingly opposing views on control, stating that God has all control and simultaneously that they control aspects of their health. Regarding God being in total control, a participant spoke about her residing at an assisted living facility:

Well, I feel like He’s in control of everything, so I feel like that’s one reason I ought to be here and that I have the doctors and the nurse here that help me, you know, really help me cope with it. But I feel like they’re God’s will for me, that I would happen to fit into this place at the time I did. (White)

Another reported:

Well like I say, that’s where faith comes in, because you’re not gonna understand everything that God do, or why He do it, or how He do it. But if you have this relationship, you’re gonna just have to accept it by faith. You’re not gonna be able to understand everything. But . . . you can’t get bitter because it happened, because this has happened before and everything. So you’re gonna just have to accept the fact that God is in control and He knows what He’s doing. (AF AM)

Participants discussed the link between God’s total control and one’s own control. Specifically, if one is able to control an aspect of health it’s because God has provided what is necessary to do so (see emotion-focused provision, God Provides). One respondent reported:

Interviewer: What role does God have with control in relation to coping with—?
Respondent: With your illness? The role that God has is for you to believe in Him, because He’s in control of everything at all times. You know, they say God knows all, even how many grains of sand on the ground, how many hairs on the head of every person. If you’ve got that belief, if you believe that, you know God’s in control of everything, but you have to believe that. You can’t just say, “I think He is. I think He’ll do this.” No. I know. You never say, “I think He’ll do it.” I know He’ll do it. And that’s how I know—He’s just in control of everything.
Interviewer: OK. So you said God is in control of everything, but you also mentioned you were in control of your own life [mentioned previous to this quote].
Respondent: Well, he makes me be in control. What I meant is the spiritual thing, God is in control; but, physically down here, I am in control because He gives me the ability to
be in control, you know. I know that comes from God. But on this earth, I can be in control because He gives me the ability to be in control. But, in the spiritual mind, in the spiritual thing, God is in control and He plants that in me. (AF AM)

Another participant discussed control in association with problem-focused provision through guidance:

Some people think they’re out of control in their health issues, but they’re really in control of their out-of-controlness. Yeah. I am, to a great degree, um . . . . As I say, God can’t heal—God could heal me if He chose to heal me. I can’t make Him heal me. So some people would believe that they’re out of control at that place, but I don’t feel out of control. I’m doing what I’ve been guided to do, and therefore I do have some semblance of control. But yeah, I feel . . . only because I feel comfortable in my relationship with God . . . the outcomes of my health issues are not scary. So I guess I have more control than most people who would maybe be fearful of their health issues. (White)

Participants’ experience of personal control in health was related to engaging in health behaviors (also see My Part). One participant stated:

Oh, talking about control over my health problems? Well, I don’t like to be like an invalid (laugh), like when I was in the wheelchair. You know, I couldn’t stand it. I like to be in control of my own life, and I think that’s one of the reasons I ended up getting out of it, is because I knew I wasn’t gonna—I just couldn’t take it, you know, and I was determined to make myself better. And I think, you know, you have to be in control of your own life, not the physical part but the mental part. You know you don’t know how to prescribe medicine and stuff like that, but anything that you can do for yourself, you should do it, at all times. (AF AM)

Another reported of control:

It means a lot. You know, you don’t want to be sick, you don’t want to be in pain, and it means a lot to be able to control that without a lot of medication, you know. That’s the reason why I like to go over and walk and do exercise. I feel like that strengthens me and helps me to cope with it. Like my feet are burning, but I still walked seven rounds, you know, this morning because I feel like I need that and I feel like that will help me be stronger and to help me to cope with these problems that I have. (White)

Respondents discussed their experience with control in the context of relinquishing. One participant discussed her experience with gaining control through relinquishing:

Interviewer: So you said as humans, we really want control. Do we lose control when we turn the situation over to God?
Respondent: No, that’s when actually gain control.
Interviewer: Tell me about that a little bit.
Respondent: That’s when you gain control, because like if you’ve got a situation and you finally turn it over to God, He’s gonna put you in the right place that you need to be in, and that’s when you gain control. You may think you got control going from this person to that person or that place to that place. But it shows you don’t have control because you keep searching. You keep searching. But like I say, it’s the hardest thing in the world because we’re human and our nature is to fix things. But most of the time, we mess it up, you know. So you give it to God, and it’s gonna keep coming to you, well, should I do this or should I do this? ‘No, Lord, it’s yours. I’m waiting on you.’

Another participant reported on her experience with attempting to control and manage situations that she could not, and subsequently, learning to relinquish:

Respondent: Just give it to Him: ‘Lord, take it. It’s not mine.’ You know, if I find myself trying to worry, ‘Lord, this is not mine. It’s not mine. The earth is yours and the, all of this belongs to you. I need to step back and let you take it, take control.’ And the hardest part is trying to take it back, and I’ve learned, once I give it up, that’s it. That’s it… I am a Type A personality, so being a Type A personality, I want to control everything. I’ve learned that. I’ve learned that being a Type A personality that that’s my nature, but I can’t—you know, years ago, I learned that I can’t control. I’m in control of nothing. I’m not even in control of the air that I breathe. You know, so if I'm not in control of the air that I breathe, why not put it in the hands of somebody who is in control of the air that I breathe? So that when I find myself trying to take control and, you know, manipulate, I step back and say, ‘I can’t do it, because I'm not in control.’ And it took me a while to learn. I just didn’t wake up, you know, with that. It took me a while, you know, of going through some different stuff in my life to learn that once I give it up, it’s over.’

The results discussed heretofore represent the product of interpretive phenomenology, for which the goal is explore the nature of the constructs of interest and describe participants’ experience with them within the context of illness and functional impairments. The following section provides results from cognitive interviews. The purpose of the cognitive interviews was to explore the manner in which older adults comprehend items on an RCOPE subscale and to better understand their decision-making and response-formation process when answering items. This endeavor represents an important aspect of a thorough examination of one’s relationship with God when coping. The RCOPE is the gold-standard measure of this aspect of coping. Previous research has indicated that this scale might have a dissimilar factor structure when
comparing White and African American respondents. A cognitive interviewing approach was used to examine potential racial/ethnic divergences regarding comprehension, decision-making, and response-formation processes for items within this scale.

**Cognitive Interviewing**

Cognitive interviewing was initiated to explore the comprehension of items on an RCOPE subscale and to attempt to better understand participants’ decision-making and response-formation process regarding each item.

**Collaborative.** Participants discussion regarding items in this factor indicated that they comprehended engagement in these types of activities to mean “using what God has provided” (especially guidance and knowledge), accepting God’s will, doing what God wants, and “doing my part.” One’s engagement in coping activities was seen as collaborative in that God was providing what was needed and that the use of what was provided was required. In response to “1. Tried to put my plans into action together with God,” a participant reported “I put my plan into action after I do prayer and ask Him how I should go, and then I follow through with the plan according to what come into my mind on that plan.” (AF AM) Regarding what it means to “2. Work together with God as partners,” a participant stated “It means that I use the brain and the energy and everything else that God gives me to make the best of it.” (White) In regards to “3. Tried to make sense of the situation with God,” a participant stated “You can always pray to God and ask Him to show you.” (AF AM) Most participants responded affirmatively to these items; however, see below.

A large minority of African American participants (6 of 13) discussed comprehending items within this factor differently, which affected their response-formation process. Regarding item #1, these participants’ comprehension was more literal (combining one’s plans with God).
When understood in this way, participants did not report engagement in this type of behavior. A participant reported:

I don’t agree with that, because . . . to me that statement means I have control. I have no control. You know, I may take my plans to God and see if that’s where He wants me to go, but I can’t put ‘em in action, you know, in relationship to Him. (AF AM)

Regarding item #2, participants’ comprehension involved establishing an equal partnership with God, which they perceived to be impossible and consequently reported not enacting. A participant reported:

Who am I to partner with God? No, I can’t see . . . I’m his child. It’s sorta like a parent: You can’t be buddy with your child. I don’t see it as partnering; I see it as needing God, needing Him for what I want or what I need, not as—because I don’t have anything to give Him. (AF AM)

For item #3, participants comprehended this item as meaning ‘making sense of God’s will.’ Responses to this comprehension of the item were negative; participants reported that you can’t make sense of God’s will and/or you don’t need to; just accept it and move on. A participant stated:

I can’t because He’s so awesome, He’s so mightiful, you can’t make no sense. Things just happen and they’re almost like . . . you know man didn’t do . . . For instance, when that storm came through, how it picked spots that it hit and left the other stuff alone and it was right in the path. You can’t make no sense out of what God does. You just accept it, know it was Him, and keep going. (AF AM).

A minority of White participants (3 of 12) had similar comprehension and response formation processes to item #3 as well.

Active Surrender. Participants’ comprehension of items within this factor mirrors the names uncovered during the phenomenological interviews regarding My part and Relinquish. The items were largely discussed to represent the same process and participants did not meaningfully differentiate among putting the rest in God’s hands, turning the situation over to God, and giving the rest up to God.
Although there did not appear to be a difference among African American and White participants’ regarding process of comprehension, there were response-formation disparities. A subset of participants discussed their disagreement with the ordering of the two major components of the items. Specifically, participants reported that the relinquishing aspect should precede the responsibility aspect. The disagreement in ordering occurred more frequently in African American participants. One participant reported her preferred ordering of an item:

Interviewer: Did what I could and put the rest in God’s hands.
Respondent: Put the rest in God’s hands and did what I could.
Interviewer: OK. Describe what putting something in God’s hands means.
Respondent: Just turn it over to Him. It’s about trust. If you trust that God will do it, then you know that I'm not capable, I don’t have enough sense to do anything. I know that. And realizing that, I know that I have to turn it all over to God. (AF AM)

**Passive Deferral.** Comprehension of the items within that factor were ubiquitous and involved not engaging in health related behaviors while concurrently making expectations that God would work on one’s behalf. Participants were uniformly adverse to these items and discussed the responsibilities that one was expected to fulfill (see My Part). Despite the ubiquitous disfavor that participants reported for these items, some African American participants discussed these items as relating to miracles. One participant reported that God does miracles, but noted that this is a rare occurrence:

Interviewer: Didn’t try much of anything, simply expected God to take control.
Respondent: Like I say, sometimes God will do it instantly, but most of the time He won’t. Because He’s got disciples here, you know, like He had back in the old days. One prime example is when Christ was crucified and he had the two thieves hanging on the cross with Him. One of ‘em was up there and everything. The other guy said, ‘We’re up here justly for what we have done,’ and then he asked Christ, ‘Lord, when you come into your kingdom, remember me.’ Christ saved him right then. He said, ‘This day you will be with me in paradise.’ (Getting choked up) So sometimes He’ll do it instantly, and then sometimes you just have to have the faith in Him. (AF AM)
In addition, some African American participants discussed the time period post-responsibility engagement and post-relinquishing as being a time that one has nothing they can do. A participant reported:

Interviewer: OK. How about this one? And this in regards to dealing with health issues. Didn't do much, just expected God to solve my problems for me.
Respondent: Mmm-mmm (laugh), no, I don’t hardly—no, I gotta say I pray. I didn’t do much. No, there’s nothing much you can do if you turn it over to Him. You do what you can do and let Him know you’re sincere, and if He knows you’re sincere, He will handle it. If He wants you to speak a word and say a word, He’ll give you that inkling or He’ll put that inkling in you, you know, to say. But I will do what I can. I talk to the Lord: ‘You’ve got to handle this. I’m looking to you now to handle this.’ (AF AM)

**Self-Directed.** Participant’s comprehension regarding these items included not incorporating God into one’s coping. Participants uniformly responded unfavorably to these items and tended to base their response on their reliance on God (see section with the same name above). No racial/ethnic divergences were noted. Respondents’ response-formation involved discussion of one’s previous attempts at engaging in an item-specified behavior and the adverse consequences. This was especially true in regards to the item, “Made decisions about what to do without God’s help.” One participant reported:

I have done that. There was a time that I didn’t—I was a Wonder Woman, Superwoman, I could do anything . . . and maybe I’d pray and maybe I wouldn’t. This was back when. So now I wouldn’t dare (laugh) try to do anything without God. (AF AM)

Another participant stated:

I’ve just done a lot of things in my life that I look back and think, You know, that would have been better if I had made it a point of prayer before . . . such-and-such. Not necessarily just health, but lots of kinds of decisions, I guess, that I just make which, I guess, are on my own, thinking I know what is best. And, of course—well, I don’t know whether anybody can pray about 100 percent of the things they do and think, but . . . generally, generally, anything works better with prayer, I think, and certainly when it gets down to matters of health and such as that . . . the more you seem to hone in on it. (White)
DISCUSSION

This study represents an in-depth exploration of one’s relationship with God and use of such a relationship when coping with health and functional impairments. Previous quantitative and qualitative research has emphasized the importance of one’s relationship with God when evaluating the association between religiosity and health. This study expands upon the extant literature and makes specific contributions in several key areas. Specifically, within the context of a comprehensively explicated description of one’s relationship with God and relational aspects of coping with health, this study uncovered the intricacies of an oft-used style of religious coping – relinquish/surrender coping. The nature of acceptance and control was examined within this context as well. The salience of God-person relationship factors was explored as a prominent facet influencing one’s coping. Areas of racial/ethnic divergence were noted in respondents’ narratives and will be discussed together in one section.

Within the cognitive interviews structured around the RCOPE measure (Pargament et al. 2000), a thorough understanding of comprehension, response-formation, and decision-making processes regarding the gold-standard measure of relationship with God when coping illuminated complexities and uncovered aspects of novel constructs in this domain. Areas of racial/ethnic divergences were uncovered that assist understanding of previous findings in the extant literature.
Nature of Relationship with God

‘Nature of Relationship with God’ represents a higher-order factor encompassing the intimacy and presence themes. This factor represents the context within which the ‘Relationship as Coping’ and ‘Experience of Coping’ factors are experienced. In the same way, the themes delineated in the ‘Relationship as Coping’ factor represent the context which ‘Experience of Coping’ is experienced (see Figure 2).

Figure 2. Representation of contextual structure of themes.
The aspects elucidated as defining the nature of one’s relationship with God included the intimacy of the relationship and God’s presence. Participants’ experience of the intimate relationship they have with God was discussed through feeling God’s presence (physically and emotionally), through behaviors of God (e.g., listening), and through God having intimate knowledge of them. The intimacy of the relationship was described as personal and related to one’s reliance on God and God being the only one that could assist them with arduous aspects of life they were facing. God’s presence represented another foundational aspect of respondents’ experience of their relationship with God. Presence was experienced as physical (God being present) and promissory (God being available on one’s behalf). Participants expressed uniformity regarding God’s continuous presence; however, the salience of God’s presence was experienced as variable. Here we see a differential experience of God when faced with adversity. Throughout respondents’ narratives, there is a theme of increased salience of one’s relationship with God in the context of struggle or enhanced illness/trouble/pain. This increased salience of the relationship is related to one’s increased sense of presence of God related to type of communication and use of God as means of secondary control attainment (thoroughly described below).

**Relationship as Coping**

**Communication to God.** Communication was the manner in which participants begin to include God into their coping process. The content of one’s communication to God was discussed in four areas: request, command, inform, and acknowledge. Poloma and Pendleton (1991) delineated four types of prayer which include aspects of process and outcome: colloquial (talking in own words, can include asking for guidance), meditative (observing/feeling presence of God, listening for response), petitionary (requesting material things), and ritual (reading from
Furthermore, they found that colloquial and meditative prayer were positively associated with well-being and inversely associated with depression and anxiety. Respondents’ experience with prayer relating to health coping and management in this study largely took the form of the colloquial and meditative typologies.

All four content areas represented important aspects of participants’ health management and coping. Informing and acknowledging prayers preceded making requests and commands. Respondents often informed God regarding: 1) the nature of a health situation, 2) the diligent efforts they had made towards engaging in their health-management responsibilities (perceived as required by God), 3) when they had reached the limits of their ability for continued engagement in health maintenance behaviors, 4) when they needed assistance, and 5) when they were relinquishing the situation to God.

The components involved in this process have important implications for coping. Informing God regarding one’s affairs represents a form of self-disclosure. Self-disclosure has been found to partially mediate the association among prayer and mental health (Black, Possel, Jeppsen, Bjerg, & Woolridge, 2014). Among respondents, informing-based prayers might serve the purpose of enhancing one’s relationship with God through self-disclosure. Furthermore, respondents’ engagement in informing God regarding the limits of their ability is a salient form of distress-related self-disclosure and prepares one for relinquishing, which relates to acceptance (discussed later). Additionally, Chaudoir and Fisher’s (2010) model of disclosure stipulates that the perceived outcome of the disclosure is based on the recipient’s reaction. Notably, informing-based communication was often followed by one’s acknowledgement that God heard the communication and was already knowledgeable regarding its contents.
Baesler’s (1999) relational prayer model (RPM) posits an association among time, relationship with God, and prayer. RPM defines two primary types of prayer: active (petitioning, praising, thanking) and receptive (openness, receptivity, and surrender). Baesler (2002) found that age was related to prayer frequency and a closer relationship with God, receptive prayer predicted relational intimacy, and active prayer is maintained while receptive prayer is increased with age. Among respondents, informing-based prayers might serve the purpose of enhancing one’s perception of intimacy with God, which was perceived as an important aspect of coping as one becomes increasingly reliant on God for provision of coping resources.

Acknowledgement prayers involved communicating to God information that participants perceived God already knew. Why engage in this redundant activity? This type of prayer appeared to represent an affirmation of beliefs regarding God’s ability, will, and plan. Specifically, one reaffirmed their faith and assurance that God would handle the situation for them by acting on their behalf in accordance with a beneficent will. Once respondents inform God regarding reaching the limits of their ability, the outcome of a situation becomes unknown and a sense of randomness is increased. Including God at this point is helpful. Randomness is aversive. Kay, Moscovitch, and Laurin (2010) found that participants exposed to randomness increase their sense of supernatural control. It might be that acknowledgement prayers are a means of increasing one’s sense of God-control through making affirmations regarding one’s belief that God is in control and will make the situation manageable.

Requesting and commanding largely included petition for the means by which to cope (e.g., requesting that God provide what is necessary for continued coping). Requests and commands included direct intervention (e.g., pain relief) and to a greater extent, assistance with engagement in primary control processes including problem-oriented intervention (e.g., give me
knowledge, guide me) and secondary control processes including emotion-oriented intervention (e.g., give me strength, help me bear it). The salience and the frequency of prayer were variable based on the nature of the situation – with times of most perceived need leading to intensified salience and increased frequency. These times usually involved experience of pain and times for which participants had reached the perceived limit of their ability. Implementation of secondary-control processes was increased via engagement in these types of prayers during these times.

The evaluation of content and the temporal order of prayer is important as they have different purposes within the context of coping with health: informing (self-disclosure of needs, engagement in secondary control processes, relationship enhancement), acknowledgement (affirmation of beliefs, decreasing a perception of randomness), request and command (preparation for engagement in primary control processes, engagement in secondary control processes).

**Communication from God.** Communication from God was experienced as other-than-audible and required vigilance. Furthermore, communication from God was often experienced as being similar to – but different from – intuition and conscience. The nature of the experience was that ideas, motivations, or actions came from outside of one’s self. Dijksterhuis, Preston, Wegner, and Aarts (2008) found that subliminal primes of God inhibited one’s sense of agency on a task and concluded that attributions are partially depended on thoughts prior to the action. Enhanced God attribution was only found among God-believers, which was reported to be an indicator of perceived efficacy of God as an agentic source. Respondents in the current study reported substantial faith in God and frequently discussed experiencing the presence of God (especially in difficult situations). Their faith enhanced their perception of the effectiveness of God’s agency while their experience of God’s presence might have acted to prime the
participants for subsequent attribution regarding God’s action. Attributing one’s actions or
intuitions to God is a means of engaging in vicarious control (aligning oneself with a powerful
other) and is particularly salient during difficult situations.

**God provides.** Previous research has indicated that people who endorse having a
relationship with God and relying on this relationship often report that they are provided with
additional resources and supports (Bhui, King, Dein, & O’Connor, 2008; Casarez & Miles, 2008;
Gall, 2004; Gall & Cornblat, 2002; Harris, 2011; Krause, 2002). The report of respondents
reaffirmed this provision.

Respondents’ discussion regarding their experience with God’s provision included two
main areas: problem-oriented and emotion-oriented. Problem-oriented provision was reported in
terms of God providing what is needed to deal with a problem directly with an expectation that
effort must be put forth to use it for coping. Emotion-oriented provision involved those things
that could not be used to fix a problem directly, but rather assist with engagement in further
coping or with emotion coping. These areas relate well to two of Lazarus and Folkman (1984)
and Folkman’s (1997) coping domains within the transactional model of stress and coping:
problem- and emotion-focused coping. Respondents were engaging in both aspects of coping
described by the model, with report of substantial assistance from what God provided. Problem-
oriented provision involved knowledge, guidance, doctors, and medication and prepared one’s
self for engagement in action oriented coping. Emotion-oriented provision involved acceptance,
strength, fortitude, etc. Emotion-oriented provision involved two notable aspects: perseverance
to engage in further coping and the ability to make peace with the current situation (“okayness”).

Within the context of respondents coping with illness and functional impairments,
problem- and emotion-focused God provision were associated with primary and secondary
control, respectively (Heckhausen & Schulz, 1995). Aspects of problem-oriented provision were those that could be used to alter one’s immediate situation (e.g., knowledge about health engagement practices, guidance regarding going to the doctor, medication). Strict primary control actions through God were represented at times when respondents reported being controlled or acting due to undeniable directives; however, most primary control actions were not experienced in this manner. Contents of emotion-oriented provision were those that could create change within one’s self and ultimately support further primary control activities (e.g., decreasing the importance of a once-sought-after goal, motivation, acceptance of current situation). Motivation is a particularly salient representation of a secondary control process in that it supports continued engagement in primary control through engagement of health management activities. Much of the content in this domain is associated with volitional control (an aspect of secondary control). Volitional control helps the individual motivationally to initiate an action sequence and follow it through to completion.

Through a relationship of intimacy and presence, the respondents experienced substantial support with health-related coping in multiple domains through perception of God’s provision. The effect of God on health coping has traditionally been thought to affect secondary control processes only. Particular emphases have been placed on vicarious control (ascribing all control through a powerful other) and positive attributional patterns in which they down-regulate the effect of losses of control on self-esteem through attributing the cause of actions to occur from external sources (i.e., God). While these processes were uncovered in this study, additional processes were illuminated as well. Regarding respondents’ experience of God’s provision during coping, it appears that they perceive God’s assistance to directly influence primary control activities through problem-oriented provisions and to support engagement of action
oriented coping and secondary control processes through provision of emotion-oriented provision. God provided doctors, medications, and the physical ability to accomplish a task (problem-oriented and related to primary control activities) as well as fortitude and the ability to accept (emotion-oriented and related to secondary control). Furthermore, use of vicarious control and positive attributional patterns are uncovered within the coping process with these respondents (see God’s Will).

**Reliance on God.** Respondents uniformly ascribed to a reliance on God within the context of coping. Participants’ experiences with reliance varied by degree, with notable increases in dependency based on the presence of illnesses and functional impairments. Additionally, respondents reported difficulty with reliance in the absence of illness and functional impairments, such as during times of youth and good health. One’s use of secondary control strategies changes over the life course (Heckhausen, Wrosch, & Schulz, 2010). As one transitions from midlife to older adulthood, secondary control striving increases while primary control processes remain stable, a change that is thought to be related to a concomitant increase in health impairments. Respondents’ reports were concordant with these findings, as these older adults reported increased engagement in secondary control processes through their relationship with God (e.g., disengaging from goals by relinquishing, making use of positive attributional patterns).

Increased reliance was discussed in addition to increases in the salience of God’s presence and increased frequency and salience of communication to God. Why do these factors increase in times of health distress? Respondents reported the perception of receiving substantial supports from God. Baesler (2003) posited an increase in relational prayer with age and an increase in perceptions of intimacy. Krause & Hayward (2013) found that those who feel close
to God were more likely to endorse use of trust-based prayer expectancies (i.e., God will answer prayers at the right time and in the right way) and that the use of such prayers were related to a heightened sense of self-esteem. Holt, Roth, Clark, and Debnam (2014) reported a mediating effect of self-esteem and self-efficacy between the association of religiosity and health engagement practices. For respondents in the current study, increasing one’s communication to God in this way – enhanced by the context of an intimate and trusting relationship with God – elevated one’s sense of self-esteem and prepared him/her for health engagement practices for which they rely heavily on God to provide what is needed.

Respondents’ feeling of reliance was substantiated through prior experiences needing and receiving God’s help. This is likely related to previous attributions made regarding God’s situational control and subsequently assimilating attributions of God’s control into one’s belief structure (e.g., I made it through because of God’s ability to control the situation. Because God has helped me before, I need to rely on God in the future). This is a salient representation of meaning-based coping.

Reliance was experienced as an integral factor in coping; however, it was noted that while a reliance on God was necessary, it was not sufficient for health management. One’s reliance on God was noted to be necessary as was engagement in aspects of health coping deemed to be the individual’s responsibility (reported to be a requirement of God). One’s reliance on God can be viewed to be potentially fatalistic and detrimental in the following way: reliance on God will delay person-directed action based on the view that one has no ability or need to attempt to alter the situation because of God’s omnipotence and unalterable will (e.g., I rely on God to fix it. God’s will is going to be done one way or another. What are my actions compared to an all-powerful God? Why should I do anything? I cannot change God’s will
anyway). In this way, one relies on God for management of a situation that is based on God’s will and is not contingent on one’s own actions. Previous research indicates that cancer fatalism was related to negative religiosity – including a less secure relationship with God and attribution of a punitive God (Tyler et al, 2013); a fatalistic attitude was associated with fewer health engagement practices.

Reliance on God among participants in the current study was not associated with an action-stalling fatalism. Rather, much of what respondents relied upon God for related to activities supporting their engagement in health management practices (help me help myself) as opposed to relying on God to fix the situation without one’s active involvement. Full examination of the nature of one’s reliance on God is important. Participants reported several aspects described above as fatalistic: total dependence on God, God provides everything that is needed, inability to do anything without God, God takes care of me, the results are up to God’s will, I turn it over completely to God, etc. If not thoroughly assessed, one might not report one’s own responsibilities in management of illness and functional decline, leading to incorrect perceptions of fatalism.

**The Experience of Coping**

**My part.** Participants uniformly discussed aspects of coping with health and functional impairments that were their responsibility. The content of responsibility was expansive and inclusive. Physical aspects of coping included: do the best I can, what I can when I can, what you can with God’s help, push yourself, just do it, do what you’ve been guided to do, pray, request wisdom and knowledge, seek knowledge and guidance, surrender, go to the doctor, follow the doctor’s directions, take medications, exercise, be healthy, and press on, among others. Mental aspects included: recognize limitations, believe in God, trust God, accept, don’t
give up, be aware of what God wants, etc. These content areas cover problem and emotion focused coping as well as primary and secondary control processes.

Regarding responsibility, respondents discussed a perception that one must do everything in one’s ability and be earnest in doing so. Responsibilities were associated with a relationship with God: respondents expressed God’s expectations of their efforts. Furthermore, the nature of God’s provision was perceived as given for the purpose of health management; using what is provided by God was a salient responsibility. This finding is in accordance with previous research (Tate, 2011). Simon, Crowther, and Higgerson (2007) reported that people perceive that God gives one the knowledge to heal and manage illness. Similarly, among African Americans with breast cancer, God is trusted to guide women to the right physician (Morgan et al, 2005). Respondents in the current study reported similar provision and noted that it has been provided so that it might be used for health management.

Respondents reported explicitly on unacceptable behavior when coping with health and functional impairments. Notably, respondents eschewed disregarding what God had provided and expecting God to heal or fix one’s problem without one’s prior effort. Furthermore, participants discussed the association between being diligent with health management responsibilities, having faith that God is intervening through those actions, and that God will continue to do so. In essence, the process of health coping involved both parties (person-God) while the outcome involved the latter.

Reaching the limits of one’s ability was an important aspect of the person-God relationship when coping. Respondents spoke about recognizing their limits as one of their responsibilities and as a salient factor relating to relinquishing. This will be interpreted more below (see Relinquishing).
God’s will. Respondents described their experience of God’s will in terms of the plan that God has for the future. Their understanding of the nature of God’s will was unclear as to its content; however, they reported clarity involving God’s will being purposeful, reasoned, and for one’s good. Furthermore, participants discussed their belief that God’s will does not include situations that are intolerable or “more than I can bear.” God’s will was often discussed in reference to one’s prayers and their outcome as well as during the process of relinquishing. Participants’ temporal reference to God’s will within the process of coping included pre- and post outcome. Regarding pre-event, respondents noted: requesting something, if I get it then good, if not, then it must be God’s will that I not get it. Regarding post event, respondents noted that any outcome was related to God’s will, unless one acted in discord with God’s will, in which case an adverse outcome became the responsibility of the person.

Folkman’s (1997) meaning-based coping provides a structure to understand respondents’ description of God’s will and its interaction in their life. Meaning-based coping involves using one’s value and belief system to make meaning of an event and includes making positive reappraisals and attributions. The nature of meaning-based coping used by respondents can be further elucidated through aspects of secondary control processes outline by Heckhausen and Schulz (1995), including predecisional, postactional, and vicarious control. Predecisional control is used in response to anticipated losses in primary control. Use of predecisional control was seen as respondents attempted to adjust to anticipated failure, perceived constraints, or disappointment by integrating their lack of clarity regarding the nature of God’s will into requests or when making relinquishing prayers (e.g., request something, if I get it then good, if not, then it must be God’s will that I don’t get it).
Postactional control is used after experienced loss of primary control and includes downward social comparison, changing of goal hierarchies, and causal account related strategies (e.g., positive attributional pattern). Respondents’ adjustment of goal hierarchies was accomplished through integration of their understanding of God’s will into the outcome (e.g., I asked for something but didn’t get it. It must not have been God’s will. I want God’s will for me because it is for my benefit. I will align my will with God’s will.). Positive attributions are made by emphasizing external causes when confronted with failure and taking credit for success. God’s will was frequently integrated into use of a positive attributional pattern, especially regarding external attribution of failure. Specifically, when actions were not sufficient for the attainment of a desired goal, then God’s will was discussed (e.g., evidently it was not meant to be). Failure was attributed to God’s will, which was described as innately good. Consequently, the ability to change one’s situation was maintained (it’s not that I couldn’t do it, it’s that it was God’s will that it was not meant to happen). Attributions regarding the agentic causality for successes were discussed in terms of God’s action as well – as opposed to attributing success to oneself (e.g., It’s not my goodness. It’s God.). Previous research discovered a similar trend, such that attributions to God’s love were made when one experiences a positive outcome (Pargament & Hahn, 1986). For older adults with illness and functional impairments who endorse a staunch reliance on God, reinforcing one’s perception of God’s power and ability to affect positive change in one’s life represents an important factor to enhance future coping experiences and ability to make such attributions. Such a strategy is similar to what has been described as vicarious control, for which one attributes all control to a powerful other.

Some respondents reported that God’s will is indeterminate and that God’s will represents directions to follow. If one does not follow God’s will, then one is “outside of God’s
will.” For respondents endorsing this as an aspect of their experience, actions that are in discord with God’s will can lead to adverse outcomes. Consequently, the negative outcome becomes the responsibility of the person. These respondents are attributing the adverse outcome to themselves, which is in opposition to what would be predicted to occur with a positive attribution process. Again, it might be that maintaining one’s perception of an omnipotent God is more important for future coping than protecting one’s own sense of control.

**God’s time.** Respondents discussed the phenomenon of experiencing God’s time as an extension of God’s will in that it is indeterminable, unalterable, and for one’s good. These beliefs regarding God’s time had the effect of leading the participant to question whether the current situation was due to God’s plan having not yet occurred. God’s time was discussed when one’s request had not been met or when there was a discrepancy between what the respondent wanted and what was currently happening. A very oft quoted sentiment is summarized as follows: Either God will do it – in His own time – or it wasn’t meant to be. This process might be understood in the following way. Dein and Pargament (2012) posited that one of the primary functions of prayer is to conserve perceptions of the sacred; consequently, prayer requests are altered based on one’s experience to avoid refuting God’s intervention in one’s life. Although participants reported that they perceived God’s will to be ultimately good, they were unclear to its specific content. Believing that the specifics of God’s will are indeterminable assists with this process. When God’s will is deemed indeterminable, its occurrence (or lack thereof) is perpetually uncertain. This allows one’s perception of God having answered one’s prayer to be in flux and able to be revised in order to secure one’s belief in the sacred. Sense of mastery – if tied to belief in God as omnipotent and acting on one’s behalf – is conserved when one allows the attribution to God’s power/will to be in constant flux and irrefutable.
Understanding of this process is further elucidated by Krause (2004), who concluded that among older adults, sense of self-worth is highest when one believes the following: God knows the best time to answer prayers and the best way to answer them. One’s situation being in discord with one’s prayer request (either in content or timing) was discussed as being consistent with God’s plan; because God’s plan was perceived as innately good and purposeful, the outcome was acceptable (i.e., It’s not what I wanted, but this is how it turned out so it must be what God wanted for me. Because it’s what God wanted, it’s OK.).

Faith. Participant experience with faith was discussed in term of knowing and being assured that God can (“He is omnipotent”) and that God will act on their behalf. Trust was a salient aspect of faith. The intimacy of one’s relationship with God as well as one’s past experience with God were noted to assist with one’s faith. The finding of increased faith being based on intimacy supports that of Krause & Hayward (2013), who reported that older adults are more likely to endorse trust-based prayer expectancies if they felt close with God. Findings regarding one’s faith being enhanced by one’s previous experience can be partly explained by a longitudinal study of prayer over a seven-year period (Hayward & Krause, 2013). Specifically, data indicated a linear increase in prayer frequency with age (including requests that God’s will be done) and increased trust with age (e.g., wait for God’s answers, God knows best).

Furthermore, the positive attribution pattern discussed previously, combined with the ways that one construes their perception of the sacred creates a structure for continued reinforcement regarding having faith that God can and God will.

Participants discussed faith as an activating agent for engagement in one’s responsibilities. “You act on it in faith that God’s going to do what He’s going to do.” One’s engagement in one’s responsibilities is bolstered by those things which are perceived to be
provided by God and by the perception that one’s actions would be supported by God. In this way, faith represented a motivating factor for health engagement and represents a facet of secondary control.

**Relinquish.** Respondents discussed a phenomenon of relinquishing the result – or current experience of discomfort in a situation – to God’s will. A similar phenomenon, often called ‘surrender,’ has been described relatively recently in religious coping literature. Gall and Cornblat (2002) discussed participant narratives that included surrendering to God’s will. Pargament, Koenig, and Perez (2000) define surrender coping as actively giving up control to God; temporally, active engagement in coping activities has been conceptualized to precede giving up control (e.g., “Did what I could and put the rest in God’s hands”). Wong-McDonald and Gorsuch (2000) defined surrender as an active choice to surrender one’s will to God’s rule. An item from the Surrender Scale includes: “When my solutions to problems are in conflict with God’s alternatives, I will submit to God’s way.” The focus of the latter involves denial of one’s will in favor of God’s or aligning one’s will with God’s. Respondents’ experience with relinquishing contained aspects of these definitions of surrender.

Relinquishing represents an acceptance of God’s will and God’s time; consequently, respondents’ experience with relinquishing can be understood well using the framework of meaning-based coping discussed above, which includes substantial use of secondary control processes (e.g., goal disengagement and positive attributional patterns).

Respondents discussed the temporal occurrence of relinquishing as both pre- and post-engagement in active health management behaviors. Despite differing time points of the act, the content of relinquishing was the same: one’s current or future experience. By relinquishing one’s situation to God’s will prior to reaching one’s limit, one is making use of a predecisional
control process by attempting to adjust to anticipated failures, perceived constraints, or disappointments (e.g., what’s happening now and whatever happens in the future is God’s will for me). Although some participants discussed initial relinquishing, the typical report mirrored the subsequent pattern: engage in one’s responsibilities, reach a perceived point of constraint regarding further available options, inform God about these events, and then relinquish. By relinquishing one’s situation to God’s will after reaching one’s limits, one is making use of postactional control processes (i.e., adjusting goal hierarchies and making positive attributions of causality as discussed above). Again, incorporation of perception of God’s will was salient.

Reaching the perceived limits of one’s ability was an important aspect of relinquishing; however, respondents stated that they do – or should – relinquish the situation to God initially. To the extent that relinquishing is an acceptance of what God’s will is (and a perception that God’s will is good and immutable), then it would be best for participants to relinquish initially. Any experiences or outcomes subsequent to the relinquishing process could potentially be attributed to God’s will and failures or disappointments would not affect one’s action potential. However, relinquishing initially represented substantial difficulty for many participants, who only did so after reaching the limits of their ability, which consequently catalyzed the relinquishing process. If initial relinquishing represents predecisional control processes with clear benefits, then why would it be so difficult? Respondents’ experience with limited relinquishing is helpful in answering this question.

Respondents discussed a phenomenon of limited relinquishing, during which time they would ‘turn it over then take it back.’ Limited relinquishing was associated with lack of belief in God’s plan and God’s time (e.g., God’s not working fast enough) and a consequential re-engagement in attempts to change the situation or to continue without God’s assistance.
Respondents reported faith, trust, and assurance regarding God’s will being immutable, God’s will being for one’s benefit, and God’s will being indeterminable (i.e., God’s will is going to occur and it will ultimately be for my good, whether I understand it or not); however, if one does not fully believe any of these aspects, then the ability to relinquish – accept God’s will – is hindered. Respondents often reported that an inability to “leave it at the altar” was a sign of weak faith. As a consequence of the difficulty of relinquishing initially, respondents often waited until they reached the limits of their ability.

One’s perception of insufficient trust and associated limited relinquishing was often discussed as being an aspect of flawed human nature and of an emphasis on self-sufficiency. The need to further manipulate the situation to one’s liking caused re-examination of potential action; however, participants’ experience with reaching the limits of their ability was helpful in this regard. Relinquishing the outcome of the situation appeared to be more palatable if one perceived that s/he had reached the limits of his/her ability to further alter the situation. At this point, disengaging from the goal – or from further attempts to reach the goal by oneself – is beneficial (i.e., it’s in God’s hands now). Furthermore, making trust-based expectancies at this point is beneficial in light of a lack of other options (i.e., God knows how and when to handle the problem).

Respondents reported their experience with relinquishing and worry, such that a lack of worry indicated one’s perception of successfully relinquishing and accepting God’s will. Previous research has found that surrendering decreases stress and perceptions of events as stressful and posited surrender style coping as a mechanism through which religiosity impacts health (Clements & Ermakova, 2012). How might relinquishing relate to stress level? As persons are coping with illness or functional impairment, they might hold a goal of reaching a
desired outcome (changing from X to Y, with the focus being on Y: My leg hurts and I have trouble walking. I want to be able to walk better) or no longer experiencing the current situation (changing from X to Y, with the focus being on avoidance of X: My leg hurts and I have trouble walking. I don’t want to be immobile). When one relinquishes attempts to alter the outcome or one’s current situation, one is are disengaging from experiential avoidance. Experiential avoidance is related to psychopathology and occurs when “a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them” (Hayes, Wilson, Gilson, Follette, & Strosahl, 1996). Disengagement from attempts to avoid aversive stimuli might be a mechanism through which relinquishing affects stress.

**Acceptance.** Acceptance has been conceptualized above as occurring in close temporal proximity with relinquishing. The act of relinquishing represents an attempt at acceptance, with God’s assistance; consequently, the same processes discussed above are relevant. Relinquishing is an acute event – which might be repeated multiple times – that occurs during the process of accepting. Accepting is a process. Acceptance is an acute event. Previous research has indicated use of accepting as a coping strategy (Hamilton, Powe, Pollard, Lee, & Felton, 2007; Tate, 2010). The targets of accepting reported by participants were similar to what was discussed as the contents of what respondents were relinquishing (e.g., health conditions, that God is in control, that God’s Will will be done, that God has a purpose, that you are not in control, God’s plan, the outcome of health situation, outcome of prayer request). Respondents reported relinquishing and acceptance to have similar antecedents and consequences. Trust in God’s will was described as required for relinquishing and was noted to be of great assistance with
acceptance. Respondents’ faith and assurance in God’s will being for their God and for God’s ability to impart God’s beneficent will were interpreted to be foundational elements linking relinquishing to acceptance (see Figure 3). Regarding emotional sequelae of relinquishing and acceptance, respondents reported that they experienced a lack of worry.

Figure 3. The importance of faith and belief in a beneficent will of God in the association between relinquishing and acceptance.

Are respondents’ accounts of acceptance a representation of a fatalistic attitude? For respondents, acceptance represented a point-in-time determination that one would stop fighting the uncontrollability of the current situation and acknowledge that God’s will for one’s life was inevitable. Based on one’s situation and level of faith, this occurred prior to or after temporally proximal environmental indicants of one’s perceived constraints. Furthermore, previous experience with an inability to change a situation enhanced persons’ ability to relinquish and accept. In this way, respondents disengaged from their repeated attempts at experiential avoidance.

Control. Respondents reported two seemingly opposing views on control. They reported that God has all control; however, they also indicated that they control aspects of their health. Participants discussed the link between God’s total control and one’s own control; if one is able
to control an aspect of health it’s because God has provided what is necessary to do so. As
discussed previously, respondents’ experience of control and its association to their relationship
with God fits well with the processes of primary and secondary control. Regarding secondary
control, participants reported using predecisional control by attempting to adjust to anticipated
failure, perceived constraints, or disappointment by integrating their lack of clarity regarding the
nature of God’s will into requests or when making relinquishing prayers. Postactional control
strategies – changing of goal hierarchies and positive attributional patterns – were also
implemented based on respondent’s understanding of God’s will and time. Volitional control –
helping an individual to initiate an action sequence and follow it through to completion – was
supported through respondents’ enhanced motivation that they received through their belief that
God requires their effort. These secondary control processes are likely what caused participants’
report regarding emotion-oriented God-provision and ultimately what enhanced their ability to
engage in primary control processes. Regarding primary control, participants reported health
engagement enhancement through receiving problem-oriented provisions from God.

*Locus of control.* Holt and colleagues’ (2003) conceptualization of spiritual health locus
of control includes active and passive dimensions. The former involves a mindset in which God
empowers people to take actions and care for themselves (e.g., “Even though I trust that God will
take care of me, I still need to take care of myself”) whereas the latter involves a mindset in
which the power is with God to protect one’s health and one’s own actions are unnecessary and
futile as a consequence (e.g., “There is no point in taking care of myself when it’s all up to God
anyway.”). Active spiritual health locus of control has been associated with health management
strategies (Debnam et al, 2012). In the current phenomenological study, respondents’ accounts
are comparable to active spiritual health locus of control through an experience of believing that
God requires their efforts and provides support for their efforts. This perception was reported to activate disease management strategies and problem-oriented coping strategies.

Wallston et al (1999) developed a scale of God locus of control that measures the extent that God exerts control over one’s disease. Examples of items include: “God is directly responsible for my condition getting worse or better” and “Whatever happens to my condition is God’s will.” Previous research has indicated that those who report a lower sense of God locus of control are more likely to adhere to an anti-retroviral medication regimen for HIV/AIDS (Finocchario-Kessler et al. 2011). Respondents’ in the current study experience indicated a high God locus of control in that they report staunch belief that God has a plan, which includes the nature and course of their illness or impairments; however, they also spoke about their ability to influence their illnesses or impairments as well as their ability to influence God’s will.

Two scales of divine control have been created, which assess the extent one believes God controls the direction and outcomes of life. Items include: “I decided God or a higher power had a plan” (Umezama et al. 2012) and “When good or bad things happen, you see it as part of God’s plan for you” (Schieman, Pudrovska, & Milkie, 2005). Respondents reported aspects of divine control, which appears to represent participants’ description and experience of God’s will.

Respondents’ experience with control contained aspect of all of these conceptualizations of locus of control (active spiritual health locus of control, God locus of control, divine control); however, participants indicated that both God and person control aspects of health and that the extent that each plays a part differs by time point in the coping process. Specifically, respondents discussed God always being in control, but requiring person-directed action and engagement in responsibilities. Perceived level of absolute constraint represented a temporal point of demarcation after which time God’s control was enhanced.
Consolidating Relationship with God and Its Effect on Health and Coping

Previous research indicates that religiosity has salient beneficial and detrimental effects on health and coping. This study provides insight into the ways in which one’s relationship with God when coping affects health and health engagement.

Beneficial. The results of this study expand understanding regarding the use of one’s relationship with God when coping with health and functional decline. This expanded understanding sheds light on the ways in which relationship with God has been associated with both positive and negative emotional and physical health outcomes. A substantial portion of respondents’ coping processes that involved their relationship with God were associated with their trust that God’s will was for their benefit and their assurance that God’s will would occur if they were diligent with their responsibilities. God’s will and time seemed to be the foundation which enhanced ability to engage in meaning-based coping and guided engagement in secondary control processes that ultimately supported primary control processes.

Ability to engage in both primary and secondary control processes is important. It might be detrimental to rely completely on primary or secondary control practices rather than incorporating both, as one’s hierarchy of goals likely contains those for which one strategy is more appropriate than another. When one is experiencing poor health and bother related to several physical problems there will be ample opportunities to engage in agentic primary control practices (taking medications, going to the doctor, etc.). However, for those with chronic illnesses, engaging in coping processes that relinquish oneself from a health goal (e.g., no more pain, greater mobility) might be beneficial in circumstances when a health goal is unattainable. Successful engagement in secondary control processes might liberate other resources which the older adult can focus on attainable goals via primary control processes. Respondents’ report of a
staunchly held belief that God’s will is immutable and for one’s good was associated with an enhanced ability to engage in secondary control processes, which becomes increasingly important as one ages (Charles, 2010; Heckhausen, Wrosch, & Schulz, 2010). Charles’ (2010) strength and vulnerability integration (SAVI) model posits that older adults display age-related enhancements in the use of strategies that act to limit or avoid exposure to aversive stimuli in light of increased vulnerability to prolonged emotional arousal. Respondents discussed age-related developments in reliance on God and relinquishing one’s situation to God’s will and control. These age-related differences and their underlying secondary control processes were reported to have beneficial effects on emotional health and might represent an aspect discussed within the SAVI model.

**Detrimental.** To the extent that God’s will and time allow for the type of meaning-based coping and secondary control processes discussed heretofore, then we would expect that those with perceptions of God’s will as punishing, punitive, and judgmental would not be able to effectively engage in such coping strategies and would have poor health and emotional outcomes as a consequence. The same holds true for those that question God’s ability to enact God’s will. Negative perceptions of God’s will have been related to physical and emotional health outcomes: faster HIV progression (Ironson et al. 2011), poor physical health (Pargament et al. 2000), low quality of life (Pargament et al. 2004), increased psychiatric symptoms (Stilton, Flannelly, Galek, and Ellison, 2013), increased depression among those with chronic pain and those with cancer (Parenteau et al. 2011; Thune-Boyle, Stygall, Keshtar, Davidson, and Newsom, 2013), among others. Similar results have been found among those who questioned God’s power or ability to implement God’s will (Pargament et al. 2000; Pargament et al. 2004). One’s belief in God interacts with understanding of God’s will and God’s power to impact health.
Consequently, thorough assessment in this area is important, especially in regard to one’s understanding of God’s will.

**Areas of Racial/Ethnic Divergence**

**A note on divergence in qualitative research.** Among respondents in this study there were differences between the racial/ethnic groups: religious affiliation, type of illness (but not level of functional impairment), and SLUMS score. When viewed from a quantitative paradigm, these differences represent confounding variables that disallow confirmatory statements regarding racial/ethnic differences in the phenomena explored due to differences being potentially related to one of these factors. Statistical control of factors increases one’s level of assurance regarding the presence of true differences between groups.

The nature of variation among groups differs when viewed from a qualitative paradigm. The focus on use of ‘divergence’ has been emphasized thus far to terminologically differentiate paradigms. Qualitative research paradigms are inductive in nature and focus on exploration. The focus of examination of potential divergences is to explore and attempt to inductively create hypotheses regarding the facets of racial/ethnic groups that have led to quantitative differences in previous scientific endeavors. Overwhelmingly, quantitative methodologies focus on phenotype-race as a demographic factor for examination of differences; however, the meaning of a nominal factor and appropriateness of the use of such a variable within psychological inquiry has been questioned (Helms, Jernigan, & Mascher, 2005; Helms & Mereish, 2013). Helms et al. (2005) advocated for replacing race as an independent variable in psychology research with variables that have more meaning and include aspects of one’s ethnicity. Furthermore, they promote transitioning away from group level traits and toward individualistic aspects of one’s experience. The specific methodology chosen for the current study – hermeneutic phenomenology – was
implemented due to its focus on the context of the phenomenon which allowed for an enhanced examination of the factors that might contribute to racial/ethnic differences.

**Divergence in lived experience.** Previous research has reported substantial racial/ethnic differences regarding religiosity, spirituality, and their association with coping and emotional and physical health. The current study, through thorough exploration of respondents’ lived experience and being-in-the-world, uncovered salient divergences. The majority of divergences involved perceived level of intimacy and ways in which one experiences intimacy with God within the relationship. Specifically, African American respondents tended to report intimacy through God’s knowledge of the respondent and communicated this intimate knowledge when speaking with God. African American participants reported an intimate presence through church in ways White participants did not. In addition, African American respondents discussed God’s presence as dwelling within and noted God’s provision of knowledge through more direct means including alteration of one’s mindset.

One’s perception of relational intimacy is enhanced through increased receptive prayer, such as communicating an awareness of God’s knowledge of oneself (Baesler, 2012). Intimacy was reported to assist with faith and trust in God, a finding similar to that of Krause & Hayward (2013), who reported that older adults were more likely to endorse trust-based prayer expectancies if they felt close with God. This enhanced trust, caused by a high level of God-person intimacy, might explain why African American respondents’ experience included less questioning of God and uncertainty regarding God’s presence. Krause (2004) reported that self-esteem is heightened among those endorsing trust-based prayer expectancies and that this benefit is greater among African Americans. Intimacy in one’s relationship with God has a salient impact on health coping, especially among African Americans.
Cognitive Interview

The purpose of cognitive interviewing was to explore the manner in which older adults comprehend items on the RCOPE and to better understand their decision-making and response-formation process when answering items. Importantly, there was a moderate degree of congruence between the intended and actual comprehension and response-making processes of the factors within the subscale. However, the differences are salient.

The collaborative coping factor represented the factor for which respondents displayed the greatest disparity among intended and actual comprehension of items. This scale is intended to measure the extent that people seek control over a stressful situation through a partnership with God in solving problems. However, respondents – especially African Americans – often comprehended items more literally and discussed the items as denoting a relationship in which ‘partnership’ meant having equal power, authority, knowledge, or responsibility. As a consequence of the literal interpretation, respondents responded negatively to these items, denoting that one cannot be equal with God in these domains. Notably, in previous research African Americans displayed greater endorsement of collaborative coping than Whites (Harris, 2011). Furthermore, in previous qualitative inquiry, African Americans have endorsed a partnership in which active participation was required (Casarez & Miles, 2008). Although some respondents reported disagreement with these items, the narratives of their experiences indicated a relationship of working together to cope with one’s health and functional impairments; however, the equality among those in the relationship was noted to be different. Results of this study indicate the need for the creation of an additional factor. The factor, similar in scope and content, should involve language that is less indicative of a relationship defined by equality. (e.g., With God in charge, I tried to put my plans into action together with God.)
Regarding the active surrender factor, there did not appear to be a difference among African American and White participants regarding process of comprehension; however, there were response-formation disparities. A subset of participants discussed their disagreement with the ordering of the two major components of the items. Specifically, respondents reported that the relinquishing aspect should precede the responsibility aspect. The disagreement in ordering occurred more frequently in African American participants. Outside of the cognitive interviews, participants discussed their experience with pre limit relinquishing; however, most discussed this as representing the ideal manner in which to cope (as opposed to the typical manner). It would be beneficial to create another factor that includes pre-relinquishing to the exclusion of post-relinquishing (e.g., When coping with illness I turn the problem over to God immediately and then do what I can).

Regarding the passive deferral factor, there were racial/ethnic divergences regarding response-formation process. Specifically, African American respondents discussed these items as relating to miracles. In addition, some African American participants discussed the time period post-responsibility engagement and post-relinquishing as being a time that one has nothing they can do. Previous research has reported that African Americans simultaneously reported high frequency of active surrender and passive deferral coping (Harris, 2011). These factors are seemingly mutually exclusive. However, the report of respondents during cognitive interviews provides insight as to how one can endorse both active surrender and passive deferral items. For example, one can ‘not do much, just expect God to solve my problems for me’ after they have ‘done what I could and put the rest in God’s hands.’ Of note in passive deferral coping is the importance of timing in the coping process. Regarding the self-directed coping
factor, there were not disparities among intended and actual comprehension, response-formation processes, or racial/ethnic divergences.

**Limitations**

As in any research, this phenomenological inquiry has limitations. First, selection of a more homogeneous sample with regard to illness or functional impairment level would have allowed for greater transferability. Transferability is akin to generalizability and represents the ability of the reader to determine if the results can apply to other contexts (Curtin & Fossey, 2007). Respondents in phenomenological analyses are recruited purposively, in order to evaluate the phenomena of interest within the context of interest. The intention of this study was to keep the context relatively broad due to the rather novel qualitative exploration of some of the primary factors targeted. As a consequence, participants were not recruited based on the presence of a particular type of illness, pain level, or level of functional impairment. Future research’s transferability could be enhanced through restricting the range of these illness/disability factors when recruiting participants. It is also noteworthy that this sample is homogeneous with regard to representing the Christian faith; thus the results are likely transferable within this religious context but not others.

**Implications and Future Endeavors**

This research has significant implications in the scientific and clinical domains of psychology.

**Scientific.** The results of this study provide a thorough and contextualized understanding of one’s use of their relationship with God when coping with illness and functional impairments. The explication of the themes uncovered in this phenomenological analysis allows for enhanced understanding of the ways that religious coping involving God can be described via extant
psychological theory, mainly the motivational theory of lifespan development and the transactional model of the stress process. Especially salient is the multitude of ways in which meaning-based coping and secondary control processes were described by respondents: predecisional (adjusting to anticipated failures, perceived constraints, or disappointments), postactional (downward social comparison, alteration of goal hierarchies, and positive attributional patterns), vicarious control, volitional control, as well as values-based reappraisals. Illumination of contextual aspects surrounding and supporting one’s use of religion will be important for future exploration and confirmation regarding the application of these theories to religious coping to explain and predict health coping behavior.

Substantial clarity was gained through exploration of relinquishing (surrender style) coping. First, the importance of faith, trust, and assurance related to God’s will and time was uncovered as a salient aspect of this type of coping. Second, the exploration of relinquishing being a religiously-oriented attempt at acceptance represents a prominent area for confirmatory research and is a promising domain for advancement in endeavors that target explaining the link between religiosity and physical and emotional health. In addition, variable timing regarding relinquishing-based coping (i.e., pre- and post activity and limits) represented a relatively novel aspect of religious coping involving one’s relationship with God. Future research should explore the timing of relinquishing and factors that affect one’s decision to relinquish. Similarly, additional research should explore what leads one to ‘take it back’ after having relinquished.

A finding that extended beyond a specific content area involved the significance of time and indicates the importance of the evaluation of one’s temporal location within the coping process. Specifically implicated is the thorough evaluation of the temporal ordering of relinquishing, control, and acceptance. An example of the importance of thorough temporal
assessment can be elucidated through discussion of the three typologies of God-person relationships reported by Polzer and Miles (2007). The typologies include: God is in the background (God is involved, but the person maintains substantial responsibility), God is in the Forefront (faith is a prerequisite and one does not collaborate with God but yields to God’s authority), and God as Healer (defer outcome to God who will heal if one’s faith is strong enough). Respondents in the current study fit within each typology described – with periods of overlap – depending on their temporal location within the coping process. For example, one begins by engaging in one’s responsibility as the primary actor while simultaneously relying heavily on God (aspects of God in Forefront and God in Background). As one begins to perceive constraints in one’s ability to further manage, one begins to transition into yielding to God’s authority and will (transition from Forefront to Background). After one has successfully relinquished – and consequently accepted – perceived inability for continued engagement, s/he defers the outcome to God’s will (God as Healer). Timing is important; engagement in all of these typologies indicates that each is a meaningful aspect of religious coping and that individual aspects should not be considered in isolation.

Respondents overwhelmingly reported God’s will to be for one’s benefit. Previous research has indicated that one’s understanding of God’s will has important implications for emotional outcomes of coping and might influence one’s health engagement. Future research should evaluate the phenomena targeted in this study within a sample of older adults who endorse a perception of a punishing and punitive will of God. The results of such a study would improve the ability of clinicians to understand the God-person underpinnings of emotional responses during coping and health management.
Another important scientific implication relates to results indicating divergences among race/ethnicities in level of perceived intimacy and the ways that one experiences intimacy with God. Intimacy was experienced as a foundational aspect of one’s relationship with God that underlies one’s interactions with God and coping. This divergence in intimacy might represent a factor that partially explains racial/ethnic differences in the extant literature. The association of one’s intimacy with other salient coping-relevant factors has been discussed previously (communication to God, faith, trust-based prayer expectancies, God’s will and time, self-efficacy, and self-esteem). These factors should be increasingly explored in future research in an effort to develop a better understanding of the meaningful aspects associated with race/ethnicity that contribute to differences noted in the literature.

**Clinical.** As discussed above, the thorough evaluation of one’s temporal location when coping with illness and functional impairments is important among several factors noted as themes in this study. Of notable clinical importance would be the evaluation of content and temporal order of prayer, use of specific coping style(s), level of perceived intimacy, and efficacy in relinquishing. Thorough evaluation is meaningful, as different types or levels of these factors appear to have disparate purposes and correlates within the context of coping with health issues.

The exploration of relinquishing as a religious-based attempt at acceptance allows for a semantic structure with which to incorporate spirituality into interventions focused on health promotion – an activity that has been perceived positively by older adults (Crowther, Parker, Achenbaum, Lanimore, & Koenig, 2002). These results provide clinicians with a theoretical understanding of several important aspects of coping involving God and allow for such an inclusion among clinicians whose clients evidence an affinity for this type of coping.
The exploration of the nature, importance of, and coping-based sequelae of reaching the limits of one’s ability represents a finding that has salient clinical implications. Reaching the limits of one’s ability – in combination with the belief in a beneficent and timely will of God – catalyzed relinquishing and acceptance of one’s condition. One’s relationship with God provides a framework that allows for acceptance of one’s health, functional impairments, pain, etc. An aversion to experience one’s situation leads to suffering – in part – through repeated attempts at experiential avoidance; suffering occurs through attempts to change what is. Acceptance and Commitment Therapy (ACT) is a therapeutic approach that attempts to assist clients better accept their suffering through altering their dysfunctional change agendas and to take actions that are congruent with one’s values (Hayes, Strosahl, & Wilson, 1999). The goal of this type of therapy is not the alleviation of aversive symptoms, but rather the reduction of attempts to avoid the nature of one’s symptomology through reduction in experiential avoidance.

ACT emanated from an attempt to develop a theory of spirituality (Hayes, 1984; Hayes, 2002). Karelka (2010) has advocated for ACT as a therapy that is sensitive to the inclusion of religious and spiritual beliefs as change agents. The experience of coping described by respondents assists in understanding ways that one’s relationship with God when coping can be incorporated into this treatment approach. The nature of one’s perception of God’s will is important in this endeavor. Respondents reported that knowledge of God’s will as for their benefit assisted them with relinquishing, accepting, “bearing it,” and enduring an onerous situation. Evaluation and incorporation of this belief into treatment could be beneficial. Conversely, evaluating that one perceives God’s will to be punitive and punishing might assist clinicians in understanding one’s resistance of their current or future situation and consequent engagement in continued experiential avoidance.
Respondents reported that relinquishing was harder to do in times of significant pain, but also reported a concomitant increase in reliance on God, communication to God, and salience of God’s presence during these times. A recent meta-analysis concluded that there were no differences in treatment effect between third-wave CBT (e.g., ACT or mindfulness) when compared with second-wave CBT (Veehof, Oskam, Schreurs, & Bohlmeijer, 2011). Wetherell et al. (2011) found no difference in pain, depression, or anxiety between those administered ACT or CBT treatment protocols, but noted greater satisfaction in the treatment among those who had engaged in ACT. ACT allows for the explicit inclusion of religiosity and relationship with God in the treatment and might allow for greater treatment satisfaction. Older adults with a predilection for religion and spirituality have advocated for its inclusion in psychotherapy, particularly among those who endorse higher positive religious coping and greater strength of religious faith. (Stanley et al. 2011). Additionally, client’s perception of therapeutic alliance is enhanced when the therapist is open to discussion of his/her client’s religious and spiritual beliefs (Cragun & Friedlander, 2012; Shumway & Waldo, 2012). Results from this study provide therapists with information regarding the discussion of religiosity and the psychological processes underlying its use within the coping process. Clinicians with little experience with or understanding of the Christian faith tradition can use these results to better understand the psychological underpinnings of their clients’ reports of therapeutically relevant activities such as ‘putting it in God’s hands’ and ‘waiting on God’s time.’ The salience of results extends beyond the domain of psychologists. Community-based clergy or chaplains can also use the results in a similar fashion. Among those who have little experience with or understanding of psychological concepts, these results provide insight into the theoretical underpinnings of the terminology frequently discussed by those they counsel.
Divergences explored among African American and White participants inform future clinical endeavors. Results from cognitive interviews indicate the presence of two additional factors that might be more salient among African Americans. A six-factor model – with the inclusion of a collaborative-and-supplicant factor and a pre-limits-relinquishing factor might capture more of the variance in person-God coping style among this group.

The results of this study – especially those regarding the salience of timing of multiple factors and of one’s understanding of God’s will – could be meaningfully aggregated into a clinically-oriented assessment of one’s use of his/her relationship with God when coping. Such a scale administered at the beginning of a therapeutic encounter could improve one’s understanding of their client’s religiously-oriented coping strategies and inform treatment planning. Furthermore, the creation of an additional factor within the RCOPE subscale could improve clinicians’ culturally competent evaluation of their clients’ use of relationship with God when coping.
REFERENCES


Appendix 1

St. Louis University Mental Status Examination

1. What day of the week is it? (1 point)

2. What is the year? (1 point)

3. What state are we in? (1 point)

4. Please remember these five objects. I will ask you what they are later.
   Apple  Pen  Tie  House  Car

5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
   How much did you spend? (1 points)
   How much do you have left? (2 points)

6. Please name as many animals as you can in one minute.
   0-4 (0 points)  5-9 (1 point)  10-14 (2 points)  15+ (3 points)

7. What were the five objects I asked you to remember? (1 point per object)

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
   87 (0 points)  649 (1 point)  8537 (1 point)

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o’clock.
   Hour markers okay (2 points)
   Time correct (2 points)

10. Please place an X in the triangle
    (1 point)

    Which of the above figures is largest? (1 point)
11. I am going to tell you a story. Please listen carefully because afterwards, I’m going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

**What was the female’s name?** (2 points)
**When did she go back to work?** (2 points)
**What work did she do?** (2 points)
**What state did she live in?** (2 points)
Appendix 2

Vulnerable Elders Survey

1. Age ___  (1 point for age 75-84, 3 points for age 85 or above)

2. In general, compared to other people your age, would you say that your health is:
   __ poor (1 point)
   __ fair (1 point)
   __ good
   __ very good, or
   __ excellent

3. How much difficulty, on average, do you have with the following physical activities:
   SCORE: 1 point for each * response in question 3a through 3f. Maximum of 2 points.

   a. stooping, crouching, or kneeling?
      __ no difficulty
      __ a little difficulty
      __ some difficulty
      __ a lot of difficulty *
      __ unable to do *

   b. lifting, or carrying objects as heavy as 10 pounds?
      __ no difficulty
      __ a little difficulty
      __ some difficulty
      __ a lot of difficulty *
      __ unable to do *

   c. reaching or extending arms above shoulder level?
      __ no difficulty
      __ a little difficulty
      __ some difficulty
      __ a lot of difficulty *
      __ unable to do *

   d. writing, or handling and grasping small objects?
      __ no difficulty
      __ a little difficulty
      __ some difficulty
      __ a lot of difficulty *
      __ unable to do *
e. walking a quarter of a mile?
   __ no difficulty
   __ a little difficulty
   __ some difficulty
   __ a lot of difficulty *
   __ unable to do *

f. heavy housework such as scrubbing floors or washing windows?
   __ no difficulty
   __ a little difficulty
   __ some difficulty
   __ a lot of difficulty *
   __ unable to do *

4. Because of your health or a physical condition, do you have any difficulty: 

   **SCORE:** 4 points for one or more * responses in questions 4a through 4e.

a. shopping for personal items (like toilet items or medicines)?
   __ yes  do you get help this? __ yes * __ no
   __ no
   __ don’t do  is that because of your health? __ yes * __ no

b. managing money (like keeping track of expenses or paying bills)?
   __ yes  do you get help with this? __ yes * __ no
   __ no
   __ don’t do  is that because of your health? __ yes * __ no

c. walking across the room? USE OF CANE OR WALKER IS OK.
   __ yes  do you get help with this? __ yes * __ no
   __ no
   __ don’t do  is that because of your health? __ yes * __ no

d. doing light housework (like washing dishes, straightening up, or light cleaning)?
   __ yes  do you get help with this? __ yes * __ no
   __ no
   __ don’t do  is that because of your health? __ yes * __ no

e. bathing or showering?
   __ yes  do you get help with this? __ yes * __ no
   __ no
   __ don’t do  is that because of your health? __ yes * __ no
Appendix 3

Religious Methods of Coping to Gain Control Subscales

The following items deal with ways you cope with negative things in your life. There are many ways to try to deal with problems. These items ask what you did to cope with your illness. Different people deal with things in different ways, but we are interested in how you cope. Each item says something 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.

1 = Not at all  2 = Somewhat  3 = Quite a bit  4 = A great deal

Collaborative Coping

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.

Active Surrender

4. Did my best and turned the situation over to God.
5. Did what I could and put the rest in God’s hands.
6. Took control over what I could, and gave the rest up to God.

Passive Deferral

7. Didn’t do much, just expected God to solve my problems for me.
8. Didn’t try much of anything, simply expected God to take control.
9. Didn’t try to cope, only expected God to take my worries away.

Self-Directed Coping

10. Tried to deal with my feelings without God’s help.
11. Tried to make sense of the situation without relying on God.
12. Made decisions about what to do without God’s help.
Appendix 4

Initial Interview Questions

Context questions
- How would you describe your physical health?
- How would you describe the physical problems/limitations you deal with?
- How stressful is dealing with your health problems/limitations?
- How do you experience stress when dealing with these problems?
- How do finances/financial concerns affect your daily life? Please explain.
- How does teachings of the church help you cope?

Relationship with God questions
- Describe your relationship with God.
- How has your relationship developed since you began having physical problems or limitations?

Interactions with God questions
- Describe the ways that you interact with God.
- How would you describe the role God has in coping with your physical problems/limitations/stresses?
- Is God always a part of your coping? Describe the situations for which God plays less of a part? More of a part?
  - Is God’s role different based on the situation? How so?
- What role do you have in coping with your physical problems/limitations/stresses?
  - Is your role different since you began dealing with your health problems? How so?
- How do you interact with God when coping? In what ways?
  - Is the interaction different based on the situation? How so?

Control questions
- Describe what “control” means to you when coping with physical problems/limitations/stresses?
- How do you obtain control in relation to your illness?
- What role does God have with control when coping with your physical problems/limitations/stresses?
- What role do you have with control when coping with your physical problems/limitations/stresses?

Acceptance questions
- Describe what “acceptance” means to you in relation to coping?
- Describe the role God has with acceptance when coping with your physical problems/limitations/stresses?
- Describe your role with acceptance when coping with your physical problems/limitations/stresses?
Appendix 5

Scripted Cognitive Interview Questions

Interview questions to follow all item responses:

Have you or do you engage in this behavior?
When was the last time you did this?
Under what circumstances did you enact this behavior?

Interview questions to follow specific item responses:

Collaborative Coping

1. Tried to put my plans into action together with God.
   Describe what “put plans into action together with God” means?
   How did you “put plans into action together with God”?
2. Worked together with God as partners.
   Describe what working together with God means.
   How do you work together with God as partners?
3. Tried to make sense of the situation with God.
   What is God’s role in “making sense of the situation”?
   Describe the ways you tried to make sense of the situation with God.

Active Surrender

4. Did my best and turned the situation over to God.
   Describe what “turning the situation over to God” means? How do you do this?
5. Did what I could and put the rest in God’s hands.
   Describe what “putting something in God’s hands” means? How do you do this?
6. Took control over what I could, and gave the rest up to God.
   Describe what “give the rest to God” means? How do you do this?
   How do you know when you have “taken control over what you could”?

Passive Deferral

7. Didn’t do much, just expected God to solve my problems for me.
   What does “didn’t do much” mean? How much did you do?
   Describe your experience with expecting God to solve your problems for you.
8. Didn’t try much of anything, simply expected God to take control.
   Describe your experience with expecting God to take control.
   Describe what “control” means in this question?”
   How would God “take control”?
9. Didn’t try to cope, only expected God to take my worries away.
   Describe your experience with expecting God to take your worries away.
   Describe what role did God played with your decision to not try to cope?
Self-Directed Coping

10. Tried to deal with my feelings without God’s help.
   Describe what “deal with my feelings without God’s help” means?
   How did you make a conscious decision to deal without God’s help or was it automatic?

11. Tried to make sense of the situation without relying on God.
   Describe what “make sense of the situation without relying on God” means
   Did you make a conscious decision to make sense without God’s help or was it automatic?

12. Made decisions about what to do without God’s help.
   Describe what “made decisions about what to do” means
   Did you make a conscious decision to make decisions without God’s help or was it automatic?
January 16, 2014

Grant Harris
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Box 870315

Re: IRB # 12-008-R1 "An Interpretive Phenomenological Analysis of Religious Coping and Relationship with God among Older Adults with Functional Impairments"

Dear Mr. Harris:

The University of Alabama Institutional Review Board has granted approval for your renewal application.

Your protocol has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 8 as outlined below:

(8) Continuing review of research previously approved by the convened IRB as follows:

(a) where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; or

(b) where no subjects have been enrolled and no additional risks have been identified; or

(c) where the remaining research activities are limited to data analysis.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number.

Your application will expire on January 15, 2015. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Study Closure Form.

Good luck with your research.

Sincerely,

[Signature]

Carpaneto T. Myles, MSM, CLM, CIP
Director & Research Compliance Officer
Office of Research Compliance
The University of Alabama