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Assessing Coping Responses within Specific Faith Traditions: Suffering in Silence, Stress, and Depressive Symptoms Among Older Catholics

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Abstract

The purpose of this study is empirically evaluate a coping response that is thought to be unique among older Catholics - suffering in silence. Two hypotheses are examined. The first predicts that older Catholics will be more likely than older Protestants to suffer in silence when ongoing economic difficulty is encountered. The second hypothesis specifies that the potentially deleterious effects of financial problems on depressive symptoms will be offset for older adults who prefer to suffer in silence. Data from an ongoing nationwide survey of older people in the United States provide support for both hypotheses.

Keywords

suffering; Catholic; financial strain; depressive symptoms

A rapidly growing body of research indicates that greater involvement in religion is associated with better physical and mental health (Oman & Thoresen, 2005). Many of these studies are based on data that were obtained from large probability samples (Schieman, Pudrovskaya, & Milkie, 2005), some of which are nationwide (Krause, 2002). However, when researchers analyze this type of data, they often pool study participants from different faith traditions into a single undifferentiated group (Ellison, Boardman, Williams, & Jackson, 2001). This data analytic strategy is based on the implicit assumption that religion means the same thing to all people regardless of their faith tradition and that the same facets of religion affect all study participants in the same way. At best, this data analytic strategy may uncover what people from different religious backgrounds have in common, but it provides little insight into the ways in which they may differ. It is clearly important to study aspects of religion that are common to people from different denominations, but given the current imbalance in the literature, more research is needed to identify the unique ways in which the relationship between religion and health may vary across people from different faith traditions (Krause, 2008).

The purpose of the current study is to identify a relatively unique way in which older Catholics may cope with the deleterious effects of stress. Orsi's (2005) intriguing historical analysis of official Catholic Church doctrine is used as a point of departure for exploring this issue. Orsi (2005) examined the official teachings and practices of the Catholic Church from the 1930s through the 1960s. This time frame is especially well suited for the current study because it represents the period in which many older Catholics came of age. Although Orsi (2005)

discusses a number of specific religious practices and beliefs, the way Catholics were taught to deal with adversity during this era represents one way in which the coping responses that are used by older Catholics may differ from the coping responses that are used by older Protestants. As Orsi points out, “There was only one officially sanctioned way to suffer the most excruciating distress: with bright, upbeat, and uncomplaining submissive endurance ... No matter how severe your suffering ... Jesus’ and Mary’s were worse, and *they* never complained” (2005, pp. 26-27, emphasis in the original). Orsi goes on to argue that, “American Catholic religious teachers practiced an especially rough theodicy in which a cheerful, compliant silence was deemed the only appropriate response to human sorrow” (2005, p. 31). Compared to Catholics, Orsi maintains that “... whining, and complaining were seen as characteristically Protestant responses while Catholics were stronger, better able to endure, better prepared to suffer” (2005, p. 33).

Two important implications for studying the coping process among older people follow from the insights provided by Orsi (2005). First, if older Catholics subscribe to the official views of their church and suffer in silence when they encounter adversity, then they may be less likely than older Protestants to turn to significant others for assistance. A recent study by Krause (2009) provides some support for this view. The purpose of this longitudinal nationwide survey was to see if older Catholics are less likely than older Protestants to receive emotional support from members of the clergy or from fellow church members when stressful life events arise. A 54-item index of stressful life events was used in this research. The findings suggest that at low to moderate levels of stress (i.e., approximately 0 to 2 stressful events), older Catholics are less likely than older Protestants to obtain emotional support over time from either fellow church members or (separately) from the clergy. However, at high levels of exposure to stress (i.e., approximately 4 stressful events), there was no difference in the amount of emotional support that older Catholics and older Protestants receive from fellow church members or from members of the clergy. When viewed from a broader perspective, the findings from this study suggest what older Catholics are less likely to do when relatively low levels of stress are encountered (i.e., obtain support from others). However, this study sheds little light on what older Catholics do instead of relying on coreligionists for assistance. Even though Krause (2009) evoked the notion of suffering in silence to explain his findings, measures of suffering in silence were not available in the data that were used in his study. As a result, it was not possible to use the results from this study as the basis for concluding that older Catholics are more likely to rely on suffering in silence to cope with the stressors that confront them.

The second implication that follows from Orsi’s (2005) work is that instead of relying on fellow church members for help in dealing with stress, older Catholics may find that suffering in silence is a viable coping option. However, there do not appear to be any empirical studies that are designed to see if older Catholics prefer to suffer in silence, nor have researchers empirically evaluated the efficacy of this potentially useful coping response. Instead, a number of investigators examine suffering without focusing specifically on suffering in silence (e.g., Black, 2006). Other researchers explore suffering in silence, but do so outside the context of religion (Knudson-Martin & Silverstein, 2009). And yet other investigators assess religiously-motivated suffering in silence but they do not empirically assess whether this coping strategy is associated with health or well-being (Krause & Bastida, 2009).

The analyses provided below were designed to fill this gap in the knowledge base by assessing whether religiously-motivated suffering in silence reduces the deleterious effects of stress on psychological well-being among older Catholics and older Protestants. However, before turning to the empirical results, it is important to reflect on how suffering in silence may help older Catholics deal more effectively with the adversities that confront them.

Identifying the Potential Benefits of Suffering in Silence

Social support is so deeply rooted in the literature on stress and health that it may be hard to understand how older people are able to cope without it. And it may be even harder to identify the benefits of eschewing social support in favor of suffering in silence because doing so rests on the seemingly untenable assumption that it is possible to derive something good from something that is widely regarded as bad and that many individuals would prefer to avoid (i.e., suffering). However, these dim assessments of suffering in silence may not be valid. In order to see why this may be so, it is helpful to first examine the potential value of suffering. Then, following this, the presumed benefits of suffering in silence may be easier to discern.

The Benefits of Suffering

The notion that suffering provides valuable lessons that may ultimately deepen one's faith has a long history in the Catholic Church. Two rather extreme examples are assessed briefly in this section to provide evidence of this. The first involves stigmatics. These are people who, for reasons that are not entirely clear, develop the same wounds that were inflicted on Jesus when He was crucified. Stigmatics may be found in the distant past of the Catholic faith right up to the present day. According to Albright (2002), St. Francis of Assisi became the first stigmatic in 1224. As Albright (2002) reports, stigmatics maintain that developing the same wounds as Jesus deepens their faith by helping them directly experience what He went through for them, and by helping them more deeply appreciate that salvation can only be found through suffering. The essence of this perspective was captured succinctly by Therese Neumann, who was a twentieth-century German stigmatic. She maintained that, "More souls are saved through suffering than through the most brilliant sermons. For that reason, we ought to never say we must suffer, but we are permitted to suffer" (as quoted in Albright, 2002, p.330).

The second example of extreme religiously-motivated suffering may be found in Kane's (2002) thoughtful discussion of victim soul spirituality. This term, which originates with Paulin Giloteaux, a nineteenth-century French priest, refers to people who plead with God to take on suffering because they believe this will help them redeem others. But suffering may do more than this. According to Kane (2002), the real value of this act arises from the belief that, "Obedient submission to suffering, rather than suffering itself, is the redemptive act, an imitation of Christ's complete acceptance of God's will" (p. 83).

Kane (2002) reports that victim soul spirituality was vigorously promoted by Joseph Kreuter, a twentieth-century Benedictine monk. She points out that the movement started by Kreuter reached its peak in the 1950s. The historical timing of this movement is important because, once again, it roughly corresponds to the time when many older Catholics came of age. Consistent with the insights provided by Giloteaux, Kreuter argues that suffering can inspire others, encourage them to emulate the sufferer, and may even save others through close identification with the sufferer (i.e., vicarious suffering).

As the discussion that is provided up to this point reveals, religiously-oriented suffering may enhance the well-being of older people in at least three ways. First, suffering may draw people closer to Christ because it helps them understand and more fully appreciate the pain He went through in order to save them. Evidence of this may be found in a recent study by Krause and Bastida (2009). The data for this qualitative study came from 52 in-depth interviews with older Mexican Americans. Strong themes involving suffering emerged from these data. Some study participants indicated that suffering made them feel more grateful to God. As one 65 year-old Catholic woman put it, "Many times I wonder why God punishes us in this way - why is God giving me all these problems? But we also have to think that God suffered more for us than we do for Him. We have to thank Him for what He went through for us rather than questioning why God is allowing this to happen to me" (Krause & Bastida, 2009, p. 118). The emphasis

this woman places on feeling grateful to God is important because a small cluster of quantitative studies suggests that the deleterious effects of stress on health are reduced for older people who feel grateful to God (e.g., Krause, 2006a). Moreover, it is evident that this woman relies on these beliefs about suffering to cope with adversity in her own life.

Second, suffering becomes a way of helping others because it shows them how to attain higher levels of spiritual development and it helps them along the road to salvation. But even more importantly, suffering also makes older people more effective support providers. Evidence of this may be found in the views of a 77 year-old Catholic woman in the study by Krause and Bastida (2009): “To believe it, you have to live it. And that is true. Before my children died, when someone died I would tell them (their relatives) I’m sorry, I know how you feel, and they told me I did not. That is, when you know what pain is, then you can really feel for others, but not until the pain is yours” (p. 118). When an older person is able to empathize with the plight of another, they are in a better position to provide support in a more effective way because they are more aware of the needs of the support recipient. This is important because research indicates that helping others offsets the noxious effects of stress on the health of older support providers (Krause, 2006b).

Third, suffering represents a way of demonstrating complete obedience to God and total acceptance of His will. This may influence the psychological well-being of older people because individuals who completely accept the will of God are in essence turning control of their lives over to Him. This is significant because several studies indicate that turning control of one’s life over to God is associated with a greater sense of well-being in late life (Krause, 2005; Schieman, Pudrovska, Pearlin, & Ellison, 2006).

The Health-Related Benefits of Suffering in Silence

The notion that suffering reflects complete acceptance of God’s will provides a point of departure for understanding why not only suffering, but suffering in silence, is regarded as a key virtue. The words chosen by Kane (2002) to illuminate this line of thinking are critical. Recall that she refers specifically to “obedient submission” and “complete acceptance” of God=s will (Kane, 2002, p. 83). As Orsi (2005) points out, the fullest expression of obedient submission and complete acceptance is silence because it reflects an understanding of the ultimate reason why problems arise in life, it conveys reverence for God even though times are hard, and it signals complete trust in His ability to provide what is needed.

Krause and Bastida (2009) provide three reasons why suffering in silence may be an effective coping mechanism. First, the respondents in their study indicate that suffering in silence helps older people feel that they will not become a burden to others. This view was expressed clearly by a 65 year-old Catholic woman: “I don’t think it’s necessary to let people know when you are suffering. They would only be burdened unnecessarily. People don’t like hearing others complaining, at least I don’t. I prefer seeing people happy and content” (Krause & Bastida, 2009, p. 120). These insights are valuable because gerontologists have argued for some time that older people value their own independence highly and they do not want to be a burden to others, especially family members (Lee, 1985). To the extent that this is true, older adults who are able to retain a sense of independence through suffering in silence should be less likely to experience symptoms of depression than older adults who feel they are a burden to others.

Another potential benefit of suffering in silence was reported by a 91 year-old Catholic man. He simply stated that people “... suffer alone ... to become stronger” (Krause & Bastida, 2009, p. 120). This older man went on to point out that by taking care of adversities by himself, he was able to strengthen existing coping skills and acquire new ones. If suffering in silence improves coping skills, then older adults who suffer in silence should be less likely to experience symptoms of depression when adversity arises in their lives.

Krause and Bastida (2009) report a third, more religiously-oriented reason why suffering in silence may be beneficial for older Catholics. This benefit arises from the belief that God will reward those who respond to stressful events with silence. As a 77 year-old Catholic woman put it, "... one should not be with an aching heart, telling everyone. It is better to be silent, keep things in your heart. Quiet. We have faith that one day God will reward us for all the tears we have shed" (Krause & Bastida, 2009, p. 120). The insights provided by this woman are important because finding favor with God should enhance feelings of psychological well-being in late life.

The discussions provided by Orsi (2005), Albright (2002), and Kane (2002) are thought provoking because they identify ways in which suffering in silence may improve the psychological well-being of older Catholics when they encounter adversity in their lives. Yet, none of these scholars explicitly linked their insights about suffering in silence with health-related outcomes. This is understandable because they are historians, and identifying ways to improve health is not a central mission of their discipline. In addition, limitations may also be found in the study by Krause and Bastida (2009). The most evident issue is that their work focused solely on older Mexican Americans. Although the wide majority of older Mexican Americans are Catholic, it is difficult to tell if the insights they provide may be generalized to older Anglos who are also Catholics. So even though the research that forms the theoretical basis for the current study is flawed in different ways, it may, nevertheless, be profitably applied to the study of stress and psychological well-being in the lives of older Catholics. It is for this reason that an effort is made in the analyses that follow to address two key questions: (1) Are older Catholics who encounter challenging stressors in their lives more likely to suffer in silence than older Protestants?; and (2) Does suffering in silence offset the deleterious effects of stress on depressive symptoms in late life (i.e., is suffering in silence an efficacious coping response)?

Methods

Sample

The data for this study come from an ongoing nationwide survey of older whites and older African Americans. The study population was defined as all household residents who were either black or white, noninstitutionalized, English-speaking, and at least 66 years of age. Geographically, the study population was restricted to all eligible persons residing in the coterminous United States (i.e., residents of Alaska and Hawaii were excluded). Finally, the study population was restricted to currently practicing Christians, individuals who were Christian in the past but no longer practice any religion, and people who were not affiliated with any faith at any point in their lifetime. This study was designed to explore a range of issues involving religion. As a result, individuals who practice a faith other than Christianity were excluded because members of the research team felt it would be too difficult to devise a comprehensive battery of religion measures that would be suitable for individuals of all faiths.

The sampling frame consisted of all eligible persons contained in the beneficiary list maintained by the Centers for Medicare and Medicaid Services (CMS). A five-step process was used to draw the sample from the CMS Files (see Krause, 2002 for a detailed discussion of these steps).

The baseline survey took place in 2001. The data collection for all waves of interviews was conducted by Harris Interactive (New York). A total of 1,500 interviews were completed, face-to-face, in the homes of the study participants. Informed consent was obtained from all study participants. Older African Americans were over-sampled so that sufficient statistical power would be available to assess racial cultural differences in religion. As a result, the Wave 1 sample consisted of 748 older whites and 752 older African Americans. The overall response rate for the baseline survey was 62%.

The Wave 2 survey was conducted in 2004. A total of 1,024 study participants were re-interviewed successfully, 75 refused to participate, 112 could not be located, 70 were too ill to participate, 11 had moved to a nursing home, and 208 were deceased. Not counting those who had died or moved to a nursing home, the re-interview rate for the Wave 2 survey was 80%.

A third wave of interviews was completed in 2007. A total of 969 older study participants were re-interviewed successfully, 33 refused to participate, 118 could not be located, 17 were too sick to take part in the interview, and 155 older study participants had died. Not counting those who had died, the re-interview rate was 75%.

Wave 4 was completed in 2008. A total of 718 older study participants were re-interviewed successfully, 61 refused to participate, 92 could not be located, 77 were too sick to take part in the interview, and 153 had died. The re-interview rate for this wave of interviews was 70%.

The analyses presented below are based on data from the Wave 4 survey because questions about suffering in silence were only administered at this time. A series of analyses are presented below. After using listwise deletion to deal with item non-response, complete data were available from between 595 and 596 older study participants. Preliminary analysis of the sample comprising 596 participants reveals that 38.8% are older men and 91.9% are older whites.¹ The average age of the respondents in this group was 82.2 ($SD = 5.6$ years). Moreover, the participants in this study reported that they had successfully completed an average of 12.4 years of schooling ($SD = 2.9$ years). These descriptive statistics, as well as the findings that are presented below, are based on data that have been weighted.

Measures

Table 1 contains the core measures that are analyzed in this study. The procedures used to code these indicators are reported in the footnotes of this table.

Suffering in silence—Four indicators are used to assess beliefs about suffering in silence. These items were developed especially for this study. They are based, in part, on the qualitative study that was conducted by Krause and Bastida (2009). A high score on these measures represents older adults who are more likely to believe it is important to suffer in silence. The mean of the brief composite that was formed by summing these indicators is 10.233 ($SD = 2.732$). The internal consistency reliability estimate for this scale is .927.

Financial strain—A measure of chronic financial strain is included in this study to assess stress. These financial strain items were taken from the work of Pearlin, Menaghan, Lieberman, and Mullan (1981). A high score denotes greater financial difficulty. The mean of this brief composite is 4.372 ($SD = 1.594$). The reliability estimate for this brief scale is .770. This financial strain measure reflects ongoing economic problems that are difficult to eradicate, especially for older people who are no longer in the work force. As Gottlieb (1997) speculates, this kind of stressor may be especially well-suited for research on religion because religion may be especially useful for coping with the effects of problems that either cannot be resolved, or that do not dissipate quickly.

Depressive symptoms—Symptoms of depression were evaluated with eight items from the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977). A confirmatory factor analysis (not shown here) was conducted with the data in the current study.

¹Preliminary analysis revealed that there were no significant race differences in the data. Consequently, the data were weighted so that the sample represents the proportion of older whites and older blacks in the United States. This helps ensure that the data are more representative and that the findings can be generalized to the nation as a whole (see Groves et al., 2004) for a detailed justification for using sample weights in this manner).

The findings reveal that these indicators reflect two dimensions of depressive symptomatology. Two separate depressive symptom outcomes were created based upon these findings. The first measure represents a depressed affect. This refers to the cognitive aspects of depression, such as feeling sad, depressed, or blue. The mean of this brief composite is 5.380 ($SD = 2.132$). The reliability estimate is .840. The second outcome, somatic symptoms, reflects the physiological manifestations of depression (e.g., having a poor appetite, having difficulty sleeping). The mean of this composite is 5.880 ($SD = 2.577$). The reliability estimate is .823. A high score on either outcome represents greater depressive symptomatology. Research reveals that it is important to distinguish between depressed affect and somatic symptoms of depression when studying older people because they are more inclined to express symptoms of psychological distress in physiological terms (Blazer, 2002).

Identifying older Catholics—All study participants were asked to report their religious affiliation. These data were used to create a binary variable that compares older Catholics (scored 1) to all other study participants (scored 0). Preliminary analysis suggests that 26.9% of the older people in the current study are Catholic whereas 73.1% reported that they affiliate with Protestant denominations. These figures are quite close to the estimated proportion of Catholics and Protestants in the United States (Ehmann, 1999). No unbelievers participated in this phase of the study.

Religion control variables—Research reveals that different dimensions of religiousness are sometimes correlated highly (Idler et al., 2003). Therefore, in order to be sure that the effects observed in the current study reflect the influence of suffering in silence on depressive symptoms, two religion control measures are included in the analyses presented below. The first has to do with the frequency of attendance at formal worship services. The mean of this measure is 5.455 ($SD = 3.115$). A high score represents more frequent attendance at worship services. The second religion control variable assesses how often older study participants pray when they are alone. A high score stands for more frequent private prayer. The mean is 6.585 ($SD = 1.986$).

Demographic control measures—The relationships among the measures of stress, religiousness, and depressive symptoms are assessed after the following demographic variables were included in the analyses: Age, sex, race, and education. Age is scored in a continuous format (i.e., years). Education is also scored in a continuous format reflecting the total number of years of education that were completed successfully by older study participants. In contrast, sex (1 = men; 0 = women) and race (1 = white; 0 = black) are represented by binary variables.

Results

The findings from the analyses that were conducted for this study are presented below in three sections. First, when the sample for this study was introduced, data were provided that indicate that some older people who participated in the Wave 1 survey did not participate in the Wave 4 interviews. Consequently, the analyses that are provided in the first section were designed to see if the loss of study participants over time occurred in a non-random manner. The data that are presented in the second section help shed light on whether older Catholics are more likely than other study participants to suffer in silence when ongoing financial difficulties are encountered. The analyses that are reported in the third section were performed in order to see if suffering in silence is more likely to offset the deleterious effects of financial strain on depressive symptoms.

Assessing the Effects of Sample Attrition

Some researchers maintain that the loss of subjects over time may bias study findings if it occurs in a non-random manner (e.g., Little & Rubin, 2002). Although it is difficult to determine the extent of this problem conclusively, some preliminary insight may be obtained by seeing whether select data from the Wave 1 survey are associated with study participation status at Wave 4. The following procedure was used to address this issue. First, a nominal-level variable containing three categories was created to represent older adults who participated in the Wave 4 survey (scored 1), older people who were presumed to be alive but did not participate at Wave 4 (scored 2), and older adults who died during the course of the follow-up period (scored 3). Then, using multinomial logistic regression, this categorical outcome was regressed on the following Wave 1 measures: age, sex, education, race, the frequency of church attendance, the frequency of private prayer, somatic symptoms of depression, depressed affect scores, and whether an older study participant was Catholic (recall that measures of suffering in silence were not administered until Wave 4 and, therefore, cannot be included in the attrition analyses). The category representing older people who remained in the study served as the reference group. Evidence of potential bias would be found if any statistically significant findings emerge from this analysis.

The results (not shown here) suggest that compared to people who remained in the study, those who dropped out but were still alive were more likely to be older ($b = .050$; $p < .001$; odds ratio = 1.051), they were less likely to be white ($b = -.495$; $p < .05$; odds ratio = .610), they were less likely to attend church often ($b = -.149$; $p < .001$) and they were more likely to affiliate with the Catholic Church ($b = .490$; $p < .05$; odds ratio = 1.633).

The findings further indicate that compared to older people who remained in the study, respondents who died were more likely to be older ($b = .109$; $p < .001$; odds ratio = 1.115), they were more likely to be men ($b = .486$; $p < .001$; odds ratio = 1.626), they were less likely to be white ($b = -.321$; $p < .05$) they attended church less often ($b = -.148$; $p < .001$; odds ratio = .863), they reported more somatic symptoms of depression ($b = .064$; $p < .05$; odds ratio = 1.066) and they experienced greater financial strain ($b = .112$; $p < .05$; odds ratio = 1.119).

Even though there is some evidence that the loss of study participants over time did not occur in a random manner, there are two reasons why the study findings may not be biased substantially. First, as Graham (2009) points out, because measures of age, sex, race, church attendance, depressive symptoms and financial strain are included in the study models, potential bias associated with these constructs is likely to be minimal. Second, as Groves (2006) convincingly argues, non-response does not necessarily translate into non-response bias. Nevertheless, the potential problem of non-random sample attrition continues to be debated in the literature. Consequently, the influence of non-random subject attrition should be kept in mind as the substantive findings from this study are reviewed.

Religious Affiliation and Suffering in Silence

The analyses that are presented in this section were designed to see whether older Catholics will be more inclined than other older adults to rely on suffering in silence as a coping mechanism when financial strain is encountered. Stated in more technical terms, this research question involves assessing whether there is a statistically significant interaction effect between religious affiliation and chronic financial strain on suffering in silence. Tests for this interaction effect were performed with an ordinary least squares multiple regression analysis. This analysis was conducted in two steps. First, the additive effects of religious affiliation, financial strain, and the other control measures were estimated in the model that predicts suffering in silence (Model 1). Following this, a multiplicative term that was formed by multiplying religious affiliation by chronic financial strain was inserted in the second step (Model 2). All independent

variables were centered on their means prior to estimating these models. The results of these analyses are presented in Table 2.

The data in the left-hand column of Table 2 (see Model 1) indicate that in general, older adults are more inclined to report they suffer in silence when they experience financial strain ($\text{Beta} = .091; p < .05$). However, the magnitude of this relationship is fairly modest. The findings also suggest that older Catholics are more likely to suffer in silence than older Protestants ($\text{Beta} = .194; p < .001$).

These analyses are extended in Model 2 (see the right-hand portion of Table 2), which assesses whether the proposed statistical interaction effect emerges from the data. These results suggest the hypothesized interaction is present. More specifically, the findings reveal that when financial strain is encountered, older Catholics are more likely than older Protestants to suffer in silence ($b = .383; p < .01$; unstandardized estimates are discussed when reviewing interaction effects because standardized estimates are not meaningful when the items have been centered on their means). Two formulas provided by Aiken and West (1991) can be used to make sure that the nature of the interaction effect has been described correctly. The first formula provides an estimate of the relationship between financial strain and suffering in silence for older Catholics as well as a separate estimate of the relationship between financial strain and suffering in silence for older Protestants. The second formula provided by Aiken and West (1991) is used for computing significance tests for each of these coefficients. The additional calculations (not shown in Table 2) indicate that financial strain is associated with suffering in silence for study participants who affiliate with the Catholic Church ($\text{Beta} = .195; p < .001$). However, these computations further suggest that financial strain is not significantly associated with suffering in silence for older Protestants ($\text{Beta} = .017; ns$). Viewed in a more general way, these data indicate that attempting to cope with stress by suffering in silence is a phenomenon that is largely unique to members of the Catholic Church.

Stress, Suffering in Silence, and Depressive Symptoms

Although older Catholics appear to be more inclined to suffer in silence when stress arises, it is not clear whether suffering in silence is an efficacious coping response. The purpose of the analyses that are presented in this section is to empirically evaluate this issue. As in the previous section, this research question is handled by testing for a statistical interaction between financial strain and suffering in silence on depressive symptoms. The statistical procedures that were used in the previous section are also used to conduct these tests. The results are provided in Table 3. Two sets of analyses were performed. The first set was conducted when depressed affect scores served as the outcome measure (see the left-hand portion of Table 3). The second set of analyses was performed when the scale assessing somatic symptoms of depression was used as the dependent variable (see the right-hand section of Table 3).

The data in the left-hand portion of Table 3 indicate that when older people experience ongoing financial problems, they report experiencing more depressed affect symptoms ($\text{Beta} = .164; p < .001$). But in contrast, the results further reveal that suffering in silence is not associated with depressed affect scores for all study participants taken together ($\text{Beta} = .073; ns$). And perhaps more importantly, the findings suggest that suffering in silence does not reduce the deleterious effect of financial strain on depressed affect scores ($b = -.026; ns$). Taken together, these results seem to suggest that suffering in silence is not an effective coping response when financial problems are encountered. However, a different picture emerges when somatic symptoms of depression serves as the outcome measure.

The data in the right-hand section of Table 3 indicate that financial strain ($\text{Beta} = .100; p < .05$) but not suffering in silence ($\text{Beta} = -.037; ns$) has a significant additive effect on somatic symptoms of depression (see Model 1). However, the results suggest that there is a statistically

significant interaction between financial strain and suffering in silence on somatic symptoms ($b = -.097$; $p < .001$; see Model 2). If this interaction effect is in the hypothesized direction, then the effects of financial strain on somatic symptoms of depression should become progressively weaker the more older people are willing to suffer in silence. Unfortunately, it may be somewhat difficult to tell if this is true given the data in Table 3 alone. Once again, the formulas reported by Aiken and West (1991) help clarify the results. This is accomplished by estimating the relationship between financial strain and somatic symptoms at select levels of suffering in silence. Although any values can be used for this purpose, the following scores were selected to illustrate the interaction effect: -1 standard deviation below the mean suffering in silence value, the mean suffering in silence score, and +1 standard deviation above the mean suffering in silence value).

The additional computations (not shown in Table 3) indicate that financial difficulties tend to exert a fairly substantial impact on somatic symptoms of depression among older adults who do not rely on suffering in silence as a coping response (i.e., older adults with a score that is -1 standard deviation below the mean suffering in silence score) ($\text{Beta} = .311$; $p < .001$). The results further reveal that the deleterious effect of financial strain on somatic symptoms of depression is still evident among older adults with average suffering in silences scores ($\text{Beta} = .147$; $p < .001$). However, the magnitude of this relationship is approximately 47% smaller, suggesting that the coping efficacy of suffering in silence is becoming more evident. Finally, the potential benefits that are conveyed by suffering in silence are especially evident for older people who rely on this coping response even more heavily (i.e., older people at +1 standard deviation above the mean suffering in silence score). More specifically, financial strain fails to exert a significant effect on somatic symptoms for older people in this group ($\text{Beta} = -.017$; ns).

Conclusions

Two major findings emerged from this study. First, the results reveal that compared to older Protestants, older Catholics are more inclined to suffer in silence when financial problems are encountered. Second, the data suggest that the deleterious effects of financial strain on somatic symptoms of depression are completely offset for older adults who strongly endorse the use of suffering in silence as a coping response. This appears to be the first time that the potential stress-buffering properties of suffering in silence have been evaluated empirically within the context of the literature on religion, aging, and health.

Although the findings from the current study may contribute to the literature, care must be taken not to overstate the extent to which suffering in silence figures into the lives of older Catholics. As the magnitude of the relationship between financial strain and suffering in silence among older Catholics reveals, not all older Catholics prefer to suffer in silence when stressful experiences are encountered ($\text{Beta} = .195$). This empirical evidence is consistent with the stance is taken by Kane (2002) in her review of the history of victim spirituality in Catholicism. Kane argues that, "Catholics have never unanimously agreed then or now with the counsel to 'smile through suffering'". Many reject the implication that God places certain people in states of permanent suffering" (p. 89). Similar views may be found in Overberg's (2003) brief treatise, *Into the Abyss of Suffering: A Catholic View*. Overberg maintains that, "The first step to grief and healing is to move from overwhelmed silence to the bold speech of lament" (2003, p. 104). Given these insights, perhaps the most prudent conclusion that can be reached in the current study is that vestiges of religious teachings from a bygone era may still be found in the way some (but not all) older Catholics attempt to deal with the stressors that confront them.

The notion that religious teachings from one historical period may still be evident decades later highlights a vast chasm in the literature on religion and health. Specifically, researchers have

not paid sufficient attention to the ways in which current religious practices are shaped by the rich historic epochs in which people spent their formative years. This essence of view was captured succinctly in the edict that was issued a half-century ago by the well-known social theorist, C. Wright Mills. He argued that a deeper understanding of the attitudes that people hold and behavior they engage in may be found by studying the intersection between history and biography (Mills, 1959). Research on religion and health has benefitted greatly because of its interdisciplinary nature. Yet, it is unfortunate to find that researchers in this field have been slow to take advantage of what historians have to offer. At least part of the difficulty may arise because researchers in other disciplines are unfamiliar with the research that historians have been conducting. This is especially true with respect to historical studies on religion. Or perhaps, researchers who study religion and health are aware of these historical data but they are uncertain about how to integrate them into their own work. Perhaps the findings from the current study help address this problem by showing one way in which the gap between sociology, psychology, and history may be bridged. Hopefully, this will open a dialog with historians, thereby enriching the quality of work on religion and health across the life course.

There is a second, more general, conclusion that emerges from the current study. Although there are a number of notable exceptions (e.g., Pargament, Tarakeshwar, Ellison, & Wulff, 2001) many studies on religion and health identify and evaluate religious practices and beliefs that are common to people of different faith traditions. This work has produced many valuable insights. Even so, it is time to offset this proclivity by conducting more research on the relatively unique religious practices and beliefs that are found within a given faith tradition. Doing so helps round out our understanding of the complex ways in which religious involvement may shape health and well-being.

Throughout the current study suffering in silence has been portrayed as a positive or beneficial coping response. Some researchers may not agree with this position. However, there are three reasons why suffering in silence may be of some benefit to older Catholics. First, as research that was discussed earlier reveals (e.g., Orsi, 2005), this coping response is consistent with official church doctrine at the time participants in the current study were in their formative years. Second, as the findings from the qualitative study by Krause and Bastida (2009) reveal, older people have identified a number of ways in which they feel they have benefited from suffering in silence. Third, and perhaps most important, the findings from the current study provide empirical support for the notion that suffering in silence is beneficial.

Even though these arguments may be plausible, some investigators may feel that the free expression of negative emotions that are encountered when stressors arise can be cathartic and, as a result, suffering in silence may not be as beneficial as it seems. There is indeed support for this alternative view in the literature. For example, research by Penedo and his colleagues indicates that the suppression of anger may compromise proper immune functioning (i.e., it may compromise natural killer cell cytotoxicity) (Penedo et al., 2006). Even so, evidence from other studies is not consistent with this research. For example, findings from an experimental study by Bushman, Baumeister, and Stack (1999) reveals that people who are encouraged to believe that expressing anger is cathartic subsequently engage in more aggressive behavior than individuals who were encouraged to think in the opposite way.

Examining three additional issues may help resolve the inconsistent findings involving the expression of anger. First, some studies suggest that it is important to take age differences into account when examining this issue. More specifically, a study by Coates and Blanchard-Field (2008) indicates that older people are less likely to express anger than either younger or middle-aged adults. This raises the possibility that suffering in silence may feel more natural and come more easily for older people and, as a result, it may be beneficial in some age groups, but not others. Second, there are clearly adaptive and maladaptive ways of expressing anger. So, for

example, negative emotions may be appropriately expressed when two individuals make a sincere effort to sit down and work out their differences. Conversely, feelings of anger may be vented through physical violence. To the extent this is true findings from studies on anger expression will depend upon how the expression of anger is managed. Third, when older people say they suffer in silence they typically mean that they do not share their emotions with relatives, friends, or fellow church members. But this does not rule out the possibility that they express troubling emotions to God in prayer.

It is difficult to arrive at a definitive conclusion regarding the beneficial effects of suffering in silence because the current study appears to be the first time that the health-related effects of this coping response have been evaluated empirically. Perhaps the value of being one of the first to investigate a substantive domain, such as suffering in silence, may be found in the questions and issues that are raised rather than in the conclusions that are reached.

Clearly, researchers need to know a good deal more about the effects of suffering in silence. One way to move research in this field forward involves developing more elaborate conceptual models that shed light on two key issues. First, greater insight is needed into why some, but not all, older Catholics believe it is important to suffer in silence. For example, it might be helpful to see if the tendency to suffer in silence is more pronounced among older people who were more deeply immersed in the Catholic faith when they were younger. This might be evaluated by assessing whether they were educated in schools that were run by the church and whether their parents encouraged them to respond to difficulties by suffering in silence. Second, the specific intervening mechanisms that link suffering in silence with health-related outcomes must be identified clearly and measured explicitly. Several potentially important intervening pathways were discussed earlier including the notion that suffering in silence strengthens older people by encouraging self-reliance and the self-development of other beneficial coping responses.

In the process of exploring these issues, researchers should pay careful attention to the limitations in the current study. Two of these shortcomings are discussed briefly below.

First, the data for this study were obtained at one point in time. This makes it more difficult to determine if suffering in silence truly reduces the odds of becoming depressed when economic problems arise. Clearly, issues involving the direction of causality can only be obtained with data that come from true experiments.

Second, older Catholics are compared to older people from all Protestant denominations taken together. Aggregating the data in this way may mask the use of suffering in silence among members of other specific Protestant denominations. Unfortunately, the sample for the current study was too small to pursue this issue empirically.

Although it is too early to use the findings from the current study to make definitive clinical recommendations, it may nevertheless be useful to briefly reflect upon the form these recommendations may take if the findings from the current study can be replicated. If suffering in silence turns out to be a beneficial coping response for older people, then care must be taken to avoid discouraging its use in all instances. Instead, it may make sense to look beyond this coping strategy to the underlying motives for using it. Doing so may help differentiate between older people who suffer in silence because they are trying to deny a problem exists (a negative coping response) and older adults who suffer in silence because they believe it is consistent with the basic tenets of their faith (a positive coping response). Following this strategy may make it easier to identify older people who do, and do not, need further clinical intervention.

It is somewhat ironic to find that research on suffering in silence is in its infancy because this fascinating religious coping response is centuries old. The very fact that the practice of suffering

in silence has persisted for so long suggests that it must be serving some beneficial function for at least some people. Delving more deeply into this issue holds out the promise of developing a richer and more finely nuanced understanding of the way in which religion may influence health.

References

- Aiken, LS.; West, SG. Multiple regression: Testing and interpreting interactions. Newbury Park, CA: Sage; 1991.
- Albright M. The stigmata: The psychological and ethical message of the posttraumatic sufferer. *Psychoanalysis and Contemporary Thought* 2002;25:329–358.
- Black, HK. Soul pain: The meaning of suffering in later life. Amityville, NY: Baywood; 2006.
- Blazer, DG. Depression in late life. third edition. New York: Springer; 2002.
- Bushman BJ, Baumeister RF, Stack AD. Catharsis, aggression, and persuasive influence: Self-fulfilling or self-defeating prophecies? *Journal of Personality and Social Psychology* 1999;76:367–376. [PubMed: 10101875]
- Coats AH, Blanchard-Fields F. Emotional regulation in interpersonal problems: The role of cognitive-emotional complexity, emotion regulation goals, and expressivity. *Psychology and Aging* 2008;23:39–51. [PubMed: 18361653]
- Ehmann, C. The age factor in religious attitudes and behavior. 1999. Available at: <http://www.gallup.com>
- Ellison CG, Boardman JD, Williams DR, Jackson JS. Religious involvement, stress, and mental health: Findings from the 1995 Detroit Area Study. *Social Forces* 2001;80:215–249.
- Gottlieb, BH. Conceptual and measurement issues in the study of coping with chronic stress. In: Gottlieb, BH., editor. *Coping with chronic stress*. New York: Plenum; 1997. p. 3–40.
- Graham JW. Missing data analysis: Making it work in the real world. *Annual Review of Psychology* 2009;60:549–576.
- Groves RM. Nonresponse rates and nonresponse bias in household surveys. *Public Opinion Quarterly* 2006;70:646–675.
- Groves, RM.; Fowler, FJ.; Couper, MP.; Lepkowski, JM.; Singer, E.; Tourangeau, R. *Survey methodology*. New York: Wiley Interscience; 2004.
- Idler E, Musick M, Ellison CG, George LK, Krause N, Levin JS, Ory M, Pargament KI, Powell LH, Williams DR, Underwood Gordon L. National Institute on Aging/Fetzer Institute Working Group brief measures of religiousness and spirituality. *Research on Aging* 2003;25:327–365.
- Kane PM. AShe offered herself up@; The victim soul and victim spirituality in Catholicism. @ *Church History* 2002;71:80–119.
- Knudson-Martin C, Silverstein R. Suffering in silence: A qualitative meta-data-analysis of postpartum depression. *Journal of Marital and Family Therapy* 2009;35:145–158. [PubMed: 19302513]
- Krause N. Church-based social support and health in old age: Exploring variations by race. *Journal of Gerontology: Social Sciences* 2002;57B:S332–S347.
- Krause N. God-mediated control and psychological well-being in late life. *Research on Aging* 2005;27:136–164.
- Krause N. Gratitude toward God, stress, and health in late life. *Research on Aging* 2006a;28:163–183.
- Krause N. Church-based social support and mortality. *Journal of Gerontology: Social Sciences* 2006b; 61B:S140–S146.
- Krause, N. *Aging in the church: How social relationships affect health*. West Conshohocken, PA: Templeton Foundation Press; 2008.
- Krause N. Receiving social support at church when stressful life events arise: Do Catholics and Protestants differ? Under review at *Psychology of Religion and Spirituality*. 2009
- Krause N, Bastida E. Religion, suffering, and health among older Mexican Americans. *Journal of Aging Studies* 2009;23:114–123.
- Lee G. Kinship and social support of the elderly: The case of the United States. *Ageing and Society* 1985;5:19–38.

- Little, RJ.; Rubin, DB. Statistical analysis with missing data. New York: Wiley; 2002.
- Mills, CW. The sociological imagination. New York: Oxford University Press; 1959.
- Oman, D.; Thoresen, CE. Do religion and spirituality influence health?. In: Paloutzian, RF.; Park, CL., editors. Handbook of the psychology of religion and spirituality. New York: Guilford; 2005. p. 435-459.
- Orsi, RA. Between heaven and earth: The religious worlds people make and the scholars who study them. Princeton, NJ: Princeton University Press; 2005.
- Overberg, RR. Into the abyss of suffering: A Catholic view. Cincinnati, OH: St. Anthony Messenger Press; 2003.
- Pargament KI, Tarakeshwar N, Ellison CG, Wulff KM. Religious coping among the religious: The relationships between religious coping and well-being in a national sample of Presbyterian clergy, elders, and members. *Journal for the Scientific Study of Religion* 2001;40:497–513.
- Pearlin LI, Menaghan E, Lieberman M, Mullan J. The stress process. *Journal of Health and Social Behavior* 1981;22:337–356. [PubMed: 7320473]
- Penedo FJ, Dahn JR, Kisinger D, et al. Anger suppression mediates the relationship between optimism and natural killer cell cytotoxicity in men treated for localized prostate cancer. *Journal of Psychosomatic Research* 2006;60:423–427. [PubMed: 16581368]
- Radloff LS. The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement* 1977;1:385–401.
- Schieman S, Pudrovska T, Milkie MA. The sense of divine control and the self-concept. *Review of Religious Research* 2005;27:165–196.
- Schieman S, Pudrovska T, Pearlin LI, Ellison CG. The sense of divine control and psychological distress: Variations across race and socioeconomic status. *Journal for the Scientific Study of Religion* 2006;45:529–549.

Table 1**Core Study Measures**

1	Suffering in Silence ^a
	A. It is best to suffer in silence.
	B. Suffering in silence makes us stronger.
	C. God will reward those who suffer in silence.
	D. Suffering in silence helps us avoid becoming a burden to others.
2	Financial Strain
	A. How much difficulty do you have meeting the monthly payments on your bills? ^b
	B. In general, how do your finances work out at the end of the month? ^c
	C. How does your household financial situation compare to that of most people your age? ^d
3	Depressed Affect ^e
	A. I felt I could not shake off the blues, even with the help of my family and friends.
	B. I felt depressed.
	C. I had crying spells.
	D. I felt sad.
4	Somatic Symptoms ^e
	A. I did not feel like eating, my appetite was poor.
	B. I felt that everything I did was an effort.
	C. My sleep was restless.
	D. I could not get going.
5	Frequency of Church Attendance ^f
	How often do you attend religious services?
6	Frequency of Private Prayer ^g
	How often do you pray by yourself?

^aThese items are scored in the following manner (coding in parentheses): strongly disagree (1); disagree (2); agree (3); strongly agree (4).

^bThis item is scored in the following manner: none (1); only a little (2); some (3); a great deal (4).

^cThis item is scored in the following manner: money left over (1); just enough (2); not enough money to make ends meet.

^dThis item is scored in the following manner: better (1); about the same (2); worse (3).

^eThese items are scored in the following manner: rarely or none of the time (1); some or a little of the time (2); occasionally or a moderate amount of the time (3); most or all of the time (4).

^fThis item is scored in the following manner: never (1); less than once a year (2); about once or twice a year (3); several times a year (4); about once a month (5); 2 to 3 times a month (6); nearly every week (7); every week (8); several times a week (9).

^gThis item is scored in the following manner: never (1); less than once a month (2); once a month (3); a few times a month (4); once a week (5); a few times a week (6); once a day (7); several times a day (8).

Table 2

Financial Strain and Suffering in Silence (N = 596)

Independent Variables	Model 1	Model 2
Age	.069 ^a (.034) ^b	.064 (.032)
Sex	.063 (.352)	.072 (.405)
Race	.017 (.169)	.008 (.076)
Education	-.220*** (-.221)	-.221*** (-.211)
Church attendance	.001 (.001)	.007 (.006)
Prayer	.144** (.198)	.163*** (.224)
Catholic	.194*** (1.196)	.200*** (1.228)
Financial strain	.091* (.155)	.077 (.132)
(Catholic X financial strain)	 (.383)**	
Multiple R ²	.116	.126

^a standardized regression coefficient^b metric (unstandardized) regression coefficient* = $p < .05$;** = $p < .01$;*** = $p < .001$

Table 3

Financial Strain, Suffering in Silence, and Depressive Symptoms

Independent Variables	Depressed Affect (N = 595)		Somatic Symptoms (N = 596)	
	Model 1	Model 2	Model 1	Model 2
Age	-.011 ^a	-.006	.076	.091 [*]
	(-.004) ^b	(-.002)	(.035)	(.042)
Sex	-.062	-.067	-.077	-.093 [*]
	(-.270)	(-.296)	(-.408)	(-.492)
Race	.056	.058	.042	.052
	(.435)	(.453)	(.038)	(.047)
Education	-.076	-.072	.002	.009
	(-.056)	(-.054)	(.020)	(.084)
Church attendance	-.164 ^{***}	-.174 ^{***}	-.191 ^{***}	-.219 ^{***}
	(-.113)	(-.119)	(-.158)	(-.181)
Prayer	.001	.002	-.013	-.011
	(.001)	(.002)	(-.017)	(-.015)
Catholic	.078	.082 [*]	.073	.086 [*]
	(.375)	(.395)	(.424)	(.498)
Financial strain	.164 ^{***}	.179 ^{***}	.100 [*]	.147 ^{***}
	(.219)	(.239)	(.161)	(.237)
Suffer in silence	.073	.078	-.037	-.023
	(.057)	(.060)	(-.035)	(-.021)
(Suffer in silence X financial strain)				
		(-.026)		(-.097) ^{***}
Multiple R ²	.094	.098	.067	.099

^a standardized regression coefficient^b metric (unstandardized) regression coefficient^{*} = $p < .05$;^{**} = $p < .01$;^{***} = $p < .001$