Aus der Klinik und Poliklinik für Palliativmedizin
der Ludwig-Maximilians-Universität München
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Spiritual Care im Lebenszyklus

Dissertation
zum Erwerb des Doktorgrades der Humanbiologie
an der Medizinischen Fakultät der
Ludwig-Maximilians-Universität zu München

vorgelegt von

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aus
Guayaquil-Ecuador

2019

Mit Genehmigung der Medizinischen Fakultät
der Universität München

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Tag der mündlichen Prüfung:	17.01.2019

INHALTSVERZEICHNIS

Zusammenfassung

Das zentrale Thema der folgenden Dissertation ist Spiritual Care im Lebenszyklus, von der Kindheit bis ins höhere Alter. Es werden zwei innovative Studien im Bereich Prävention und Therapie vorgestellt; beide wurden in internationalen wissenschaftlichen Zeitschriften veröffentlicht.

Die erste Studie befasst sich mit der Prävention von sexuellem Missbrauch an Kindern und Jugendlichen durch die Verbesserung von Empathie bei denjenigen Mitarbeitern, die mit dieser lateinamerikanischen Bevölkerungsgruppe arbeiten. (Man-Ging et al., 2015). Die Ergebnisse lenken den Blick auf die Konzeption des Managements und die Bewertung von Empathie in den Dimensionen: kognitiv, emotional, situativ und dispositionell. Hierzu wurde ein e-learning Programm zur Prävention erprobt. Die Stärkung empathischer Kompetenzen und die Verbesserung der Primärprävention erwiesen sich als Faktoren, die den Erfolg von Trainingsprogrammen zur Prävention von sexuellem Missbrauch beeinflussen.

Die zweite Arbeit untersucht eine Gruppe deutscher katholischer Priester, die aufgrund ihres fortgeschrittenen Alters und ihrer gesundheitlichen Probleme als eine gefährdete Gruppe betrachtet werden kann. Bei der Auswertung der Interviews konnte der Zusammenhang zwischen Bewältigungsmechanismen (coping), der Identifikation mit der priesterlichen Rolle und einem aktiven Bewältigungsstil gesichert werden. Umgekehrt korreliert ein negativer religiöser Bewältigungsstil mit Vermeidungstendenzen und mangelnder emotionaler Bewältigung. Zum anderen gibt es eine starke Korrelation zwischen emotionalem Coping und Stressfaktoren sowie der Kontrolle über negative Emotionen. Dieser Umstand beeinflusst auch die Zunahme von psychosomatischen Symptomen, wie z.B. Angst und Somatisierungen.

Der Fokus beider Studien liegt auf einem Verständnis ganzheitlicher spiritueller Begleitung, also aus medizinischer Sicht auf Sorgfalt und spiritueller Betreuung.

Resume

The present dissertation comprises a central topic that has been studied, which is spiritual care at the extremes of the life cycle: childhood and old age. Two original and innovative research studies within the scope of prevention and therapy are being presented. Both studies have been published in international scientific journals.

The first article is about prevention of sexual abuse in the case of children and adolescents, improving the empathy of the staff that works with this population in Latin America. (Man-Ging et al., 2015). The results of this research point to the understanding of management and assessment of empathy acknowledging its various dimensions: cognitive, emotional, situational and dispositional, for which an e-learning prevention program was carried out. The strengthening of the empathic competences and the improvement of primary prevention are factors which influence education towards the prevention of sexual abuse.

The second study analyses a vulnerable group of German Catholic priests due to advanced age and health issues. In this research can be seen how coping mechanisms, the identification with the role of a priest, and the style of active coping of the interviewed persons associate. On the contrary, negative religious coping is correlated with avoidance and emotional coping. On the other hand, there is a strong correlation between emotional coping and stress factor and the lack of control of negative emotions. This circumstance also influences the increase of psychosomatic symptoms, such as anxiety and somatization.

The focus of both studies points to an understanding of integral spiritual care, i.e., from a medical perspective, and from spiritual care and attention.

Resumen

El presente trabajo de disertación comprende un tema de estudio central que es el Acompañamiento en los extremos de los ciclos de la vida (“Spiritual Care im Lebens-zyklus“): la niñez y la senectud/vejez. Se presentan dos estudios de investigación original e innovadora en el campo de la prevención y de la terapia. Ambos estudios han sido publicados en revistas científicas internacionales.

El primero versa sobre la prevención del abuso sexual de niños y jóvenes desde el mejoramiento de la empatía en el personal que trabaja con esta población en América Latina (Man-Ging et al., 2015). Los resultados de dicha investigación apuntan a la concepción del manejo y valoración de la empatía desde sus diferentes dimensiones: cognitiva, emocional, situacional y disposicional, a través de un programa e-learning de prevención. El fortalecimiento de las competencias empáticas y el mejoramiento de la prevención primaria son factores que influyen en la formación para la prevención del abuso sexual.

El segundo trabajo estudia un grupo vulnerable por su edad avanzada y problemas de salud en sacerdotes católicos alemanes. En esta investigación se observa una asociación entre mecanismos de afrontamiento (coping) y la identificación con el rol sacerdotal de las personas entrevistadas y un estilo de afrontamiento activo.Por el contrario, el afrontamiento religioso negativo se correlaciona con el evitamiento y el afrontamiento emocional. Por otro lado, se observa una fuerte correlación entre el afrontamiento emocional y los factores de estrés y la falta de control de las emociones negativas. Esta circunstancia también influye en el aumento de los síntomas psicosomáticos, como la ansiedad y la somatización.

El enfoque de ambos estudios apunta a una comprensión del acompañamiento espiritual integral, es decir, desde la perspectiva médica, del cuidado y la atención espiritual.

EINLEITUNG

Spiritual Care ist inzwischen auch im deutschen Sprachraum die Bezeichnung für eine gemeinsame Kompetenz von Pflege, Medizin und anderen Gesundheitsberufen (Frick & Roser, 2011). Die Seelsorge von Kirchen und anderen Religionsgemeinschaften wird in Abhängigkeit von den institutionellen Rahmenbedingungen mehr oder minder intensiv in die interprofessionelle Aufgabe von Spiritual Care einbezogen. Der jeweilige Beitrag der Seelsorge zum Gesundheitswesen variiert von Situation zu Situation (Roser, 2017), nicht nur in der Palliativmedizin (Kuhn-Flammensfeld et al. 2018) und Geriatrie (Man-Ging et al. 2015), sondern auch am Anfang des Lebens (Thiel, 2016) sowie im Kindes- und Jugendalter (Champagne, 2016: Gontard, 2016).

Die vorliegende kumulative Dissertation umfasst zwei Arbeiten, die jeweils für Spiritual Care an beiden Polen des Lebenszyklus stehen, nämlich Kindheit und Jugend (Schutz des Kindeswohls und der Integrität von Adoleszenten durch Prävention und Empathie) einerseits und Alter andererseits (Krankheitsverarbeitung älterer römisch-katholischer Seelsorger). Beiden Arbeiten gemeinsam ist die Perspektive des Carings, einer umfassenden fürsorglichen Haltung, die auch spirituelle Aspekte und die Dimension des Self-Carings einschließt.

1. Die Empathie: Die Seelsorge setzt den Glauben an den Menschen voraus

Die Prävention sexuellen Missbrauchs an Kindern und Jugendlichen stellt ein Problem dar, welches geographische, soziale und kulturelle Schranken der modernen Gesellschaft überschreitet. Die frühzeitige Erkennung, klare Benennung, Sanktionierung und wissenschaftliche Erfassung von abusiven Situationen ist sowohl historisch als auch kulturell paradigmatischen Veränderungen sowie Prozessen der Verleugnung (Nicht-Wahrhabenwollen) und Bagatellisierung bzw. Bewusstwerdung unterworfen. Dies gilt nicht nur in individueller Hinsicht, sondern auch im Hinblick auf Familien-, Sozial- und Gesellschaftssysteme.

Empathie ist unabdingbar, wenn es darum geht, Respekt zu fördern und den anderen Menschen in seiner Würde und Suche nach Wohlbefinden wahrzunehmen. Es ist

der Ruf nach Ganzheit - sich selbst und anderen gegenüber, aber auch in sozialer und politischer Perspektive - durch Entwicklung der eigenen Fähigkeit, die Perspektive des Anderen einzunehmen und somit die psychischen Prozesse bei sich selbst und beim Gegenüber zu verstehen.

Das Phänomen „Empathie“ ist so alt wie das Leben selbst. Die Gründerväter der Psychologie benutzten den Begriff „Einfühlung“, sie entlehnten dieses Wort aus der Philosophie. Zum Beispiel nutzt Robert Vischer die Fähigkeit sich „hinein zu fühlen“ (feeling in/feeling into) (Vischer, 1873/1994), um die Wahrnehmung eines Kunstwerks zu bezeichnen. Die wissenschaftlichen Überlegungen, welche sich auf diese Prozesse beziehen, wurden von Theodor Lipps aufgenommen, der für die Ästhetik das Wort „Einfühlung“ prägte. Hiermit bezog er sich auf die Studie ästhetischer Emotionen. Später gibt Edward Titchener auf Englisch das Wort “empathy” an (Pinotti, 2010), welches bis zum heutigen Tag gültig ist. Beim „Fühlen-können“ handelt es sich darum, die Stimmungslagen einer anderen Person zu erkennen und zu erleben, ohne diese jedoch mit den eigenen zu verwechseln, d.h. „mit dem Anderen zu fühlen“ und somit in sich selbst zu spüren, was der andere Mensch fühlt, denkt, erlebt.

Für Gesundheits- und Sozialberufe ist die Empathie ein einzigartiges Instrument, um körperliches oder/und seelisches Leid lindern zu helfen. Dennoch erscheinen sofort einige Fragestellungen: Wie soll man Empathie in einer komplexen Wirklichkeit verstehen? Wie können wir die heilende Wirkung von Spiritualität und Glauben, sei dieser religiös oder nicht, in Krisensituationen, d.h., bei Schmerz, Frustration und Tod verstehen? Wie kann man der begrifflichen Verwirrung zwischen Empathie, Sympathie, Mitleid, Erbarmen und Barmherzigkeit entgehen? Hierfür ist es notwendig, den empathischen Prozess, so wie er in der Wissenschaft diskutiert wird, sowohl aus kognitiver als auch aus affektiver Sicht, zu verstehen. Hinzu kommt die Motivation zur Handlungsbereitschaft, welche eine Fähigkeit zur Einsicht voraussetzt. Mit anderen Worten: es ist nicht genug, sich in eine andere Person hinein zu versetzen und diese zu verstehen, sondern auch den eigenen Reaktionswillen zu stärken und in Verhaltensweisen umzusetzen.

Der Artikel „*Improving empathy in the prevention of sexual abuse against children and youngsters*“ beschreibt die Pilotierung eines E-learning Programms. Ziel des Programms ist die Steigerung empathischer Fähigkeiten bei Personen, die im edukativen Bereich mit Kindern und Jugendlichen arbeiten. Hier wird von der Hypothese

ausgegangen, die Früherkennung sexuellen Missbrauchs an Kindern und Jugendlichen durch Förderung empathischer Fähigkeiten zu verbessern und die Primärprävention zu stärken. Die Pilotierung des Programms wurde mit einer Gruppe von 94 Personen aus neun lateinamerikanischen Ländern begonnen, davon haben 42 Personen intensiv diese Fortbildung besucht und ein Zertifikat der Universität Gregoriana erhalten. Die Studie wurde integrativ durchgeführt, um die quantitativ erhobenen Ergebnisse qualitativ zu untermauern.

Die Studie kann belegen, dass Empathie nicht nur eine Art und Weise ist, die Emotionen der Menschen versteht oder Mitgefühl gegenüber deren Bedürfnissen hat. Vielmehr hängt Empathie auch vom Engagement ab, mit dem man eine gegebene Situation angeht (wie es der Fall bei sexuellem Missbrauch Minderjähriger ist). Um sich als empathische Person zu entfalten, ist es notwendig, in einem Lernprozess empathische Fähigkeiten im Beruf zu entwickeln: Das ständige soziale Miteinander, abhängig von Alter und Reifung des Gehirns (Georgi, Petermann, & Schipper, 2014), erzeugt wichtige Effekte in diesem Prozess. Das Pilotprogramm zur Prävention, welches bei dieser Studie bewertet wurde, ist eher auf kognitive Zusammenhänge der Prävention fokussiert. Die durchgeführte Studie hat gezeigt, dass Empathie auf die Notwendigkeit aufmerksam macht, mit Menschen aus einer gefährdeten Umgebung in Verbindung zu stehen. Die Anerkennung der eigenen Schwächen ist ebenso Teil des Lernprozesses, um die empathischen Fähigkeiten gemäß den Bedürfnissen und der spezifischen Kontexte zu verbessen, um somit Konflikte zu lösen und das Wohl der Kinder und Jugendlichen zu fördern und zu schützen. Eine Implementierung des E-Learning- Programms bedarf weiterer Studien. Besonderer Fokus ist hier auf die Erhöhung der männlichen Teilnehmerzahl zu legen.

Der Artikel „*Improving empathy in the prevention of sexual abuse against children and youngsters*“ wurde vom Verfasser dieser Dissertation in Hauptautorenschaft erstellt, d.h. die Formulierug der Forschungsfragen, die Auswahl der Methoden und der Teilnehmer, sowie die Begleitung des Präventionsprogrammes wurden selbständig und eigenverantwortlich vom Erstautor dieser Arbeit durchgeführt. Selbiges gilt für die Analyse der empirischen Daten und der Diskussionselemente, die Formulierung der Ergebnisse und die Zusammenfassung, sowie das Einreichen zur Veröffentlichung bei der Zeitschrift „Journal of Child Sexual Abuse“, die Korrektur und die Endbearbeitung. Die

Ko-Autoren haben zum Revisionsprozess im Rahmen von Diskussionsveranstaltungen beigetragen.

2. Die schützenden Faktoren der psychosomatischen Gesundheit

Spiritual Care ist auf die Resilienz von Individuen und Gruppen, auf die protektiven Faktoren der psychosomatischen Gesundheit ausgerichtet. An dieser Stelle sollte hervorgehoben werden, dass der Wert der Spiritualität sich nicht nur auf ihren Nutzen in Krisenzeiten beschränkt, sondern mit dem täglichen Leben verbunden ist (Pargament, 2011). Die jeweilige Nutzung des spirituellen Copings zeigt, wie die Person ihre Spiritualität als bewussten oder unbewussten Schutz integriert hat. Die Schwierigkeiten, welche bei diesem Prozess auftreten, sind Chancen in Form von Herausforderungen, um eine erfolgreiche spirituelle Wandlung zu erreichen. Alles hängt davon ab, wie die Person diese beiden Fähigkeiten anwendet – sei es zum Wachsen oder zur problematischen, pathogenen Entwicklung. Deshalb kann man mit Pargament sagen: Die Spiritualität kann sowohl Teil des Problems, als auch Teil der Lösung sein.

Flexibilität ist Grundlage für die Akzeptanz eines bestehenden Problems und damit einer gelungenen Bewältigung. Ebenso muss man lernen, selbständig mit den anderen zusammen zu leben. Im Gegensatz dazu sind Strategien einer ungesunden Bewältigung solche Mechanismen, die die Aufmerksamkeit vom Problem ablenken, um es zu vergessen oder den situativen Stresspegel zu senken.

In der durchgeführten Forschung unter Seelsorgern in Deutschland, *„Coping Mechanisms for Psychosomatic Symptoms among Aging Roman Catholic German priests“*, korreliert die positive religiöse Bewältigung damit, dass die Probanden sich mit ihrer Priesterrolle identifizieren sowie mit einem aktiven Copingstil. Die negative religiöse Bewältigung hingegen korreliert mit vermeidendem und emotionalem Coping. Ebenso fehlt in diesem Falle die Identifikation mit der Rolle als Priester. Daraus ergibt sich auch die Wichtigkeit der Identifikation mit der Rolle als einem Schutzfaktor psychosomatischer Gesundheit. Zum anderen zeigt dies eine starke Korrelation zwischen emotionaler Bewältigung und Stressfaktoren und dem Fehlen von Kontrolle negativer Emotionen. Dieser Umstand hat ebenfalls Einfluss auf das Ansteigen psychosomatischer Symptome wie Angst und Somatisierung. Sollten die notwendigen Ressourcen und soziale Unterstützung fehlen, kann dies zu Depressionen führen.

Das hier vorliegende Original des Forschungsartikels wurde vom Erstautor in den folgenden Phasen entwickelt: Formulierung der Forschungsfragen, Analyse der empirischen Daten, Formulierung der Ergebnisse, Analyse der Diskussionselemente und der Zusammenfassung, Einreichen zur Veröffentlichung bei der Zeitschrift „Journal of Religion and Health“, Korrektur und Endbearbeitung. Die Ko-Autoren haben zum Revisionsprozess, der Korrektur und der Diskussion beigetragen.

Erster Artikel

Improving empathy in the prevention of sexual abuse against children and youngsters

Journal of Child Sexual Abuse, 24:7, 796-815, 2015

ISSN: 1053-8712 print/1547-0679 online
DOI: 10.1080/10538712.2015.1077366

Improving empathy in the prevention of sexual abuse against children and youngsters

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The aim of this research is to study the improvement of empathy in child-care professionals (i.e., teachers, psychologists, social workers) involved in the prevention of sexual abuse against children and youngsters. An E-Learning training pilot program was conducted with pre- and post-measures (T1 = at the beginning and T2 = after 6 months) using the program's standardized questionnaires of Situational Empathy and the Interpersonal Reactivity Index (IRI) as a Dispositional Empathy measure. A sample of 42 experienced professionals involved in activities with children and youngsters was obtained from the International Movement of Popular Education in Latin America called "Fe y Alegría." Significant progress was found in the scales of Situational Empathy and in some Coping subscales. The final outcomes seem to indicate that the prevention program elicits important changes in the cognitive sphere and that these changes are more intense when the implication level for the situation is greater. This research shows that empathy can be improved through professional experience and careful situational involvement.

KEYWORDS child-care professionals, E-Learning, emotions, empathetic communication, Fe y Alegría, intervention pilot program

Received 13.01.2015; revised 28.06.2015; accepted 29.06. 2015; Published online: 02.11.2015.

INTRODUCTION

This research treats the topic of empathy as a cognitive, affective and dispositional process toward another's emotional state or context. There is an abundance of literature about it; the intention of this study is to explore this ability of understanding and sharing (Decety & Jackson, 2004; Shamay-Tsoory, 2011) and how it may be used as a child protection resource with a compassionate approach (Carich, Metzger, Baig, & Harper, 2003). Some aspects of adult empathy were measured in order to obtain relevant results, such as creative ways of accompanying adults through an E-Learning pilot program on an interdisciplinary basis and of developing interpersonal skills to function effectively on empathetic communication (Bylund & Makoul, 2002; Carkhuff, 1971; Levetown, 2008) in the prevention of sexual abuse of children and youngsters.

Empathy

Empathy is a complex construct. Thus, it is difficult to reach consensus regarding its definition (Nowak, 2011; Spreng, McKinnon, Mar, & Levine, 2009) and how to measure it. In the words of one study, "Empathy has been inconsistently defined and inadequately measured" (Reniers, Corcoran, Drake, Shryane, & Völlm, 2011, 84). Theorists frequently point to the use of the term "*Einfühlung*" by the German philosopher Robert Vischer in his thesis *"Über das optische Formgefühl: Ein Beitrag zur Aesthetik." Einfühlung* refers to the ability to *"feel in"* or to *"feel into"* (Vischer, 1873/1994) in order to explain the viewer's actual perceptual engagement with a work of art (Koss, 2006). Earlier, in the eighteenth century, romantic writers like Herder and Novalis had used the verbal formula "*sich einfühlen*" for the internal process of contemplating beauty. It was subsequently translated into English by Edward Titchener as *empathy*, which comes from the Greek word "εμπάθεια", the quality to *"feel inside"* someone else (Pinotti, 2010).

An integrative approach to empathy encompasses multiple dimensions, such as affective sharing, awareness of self and others, emotional regulation, perspective-taking, and empathy-related responding (Lietz et al., 2011). These are the qualities that enable humans to apprehend another person's condition or state of mind (Gilet, Mella, Studer, Grühn, &

Labouvie-Vief, 2013) and then to feel the emotions of the other in order to better understand the situation they are going through and to offer the possibility of taking empathetic action. Neuronal plasticity throughout someone's entire lifespan indicates that a person's basic empathetic abilities are continually modulated by interpersonal socio-emotional stimulation and challenges. Therefore, involvement in pro-social attitudes is independent of age or brain maturation level (Georgi, Petermann & Schipper, 2014).

Prevention of sexual abuse

There are many studies of child maltreatment that analyse risk factors and the conditions that have led to the concealment of problems (Nurcombe, 2008; Sinanan, 2011). Sexual abuse of children and adolescents is most commonly committed at home or by a person known to the family (Lazenbatt, 2012). Sexual violence—by both parents and educators—also takes place in schools and other educational settings. Other risk factors for sexual abuse include: social and cultural patterns of behavior, social isolation, drug and alcohol abuse, socio-economic factors (including inequality and unemployment), dysfunctional families (conflicts and instability), delinquent behaviors, psychiatric illness, race/ethnicity, presence of disabilities, prior victimizations, domestic violence and substance abuse by caregiver(s) in one's household, sexual arousal and pornography, low academic performance, peer pressure, poverty in the family, insecure attachment style, stressful environment, and gender stereotypes (Massetti et al., 2011; Wilson & Widom, 2010).

State of the question

The current research about child protection points out notable data: about 20% of women and 5-10% of men suffered sexual abuse as children; 14% of girls and 7% of boys under 18 years old in institutional care have experienced sexual violence (Douglas & Finkelhor, 2005; Sperry & Widom, 2013). According to this data, researchers have found that younger children are under greater threat of physical violence, whereas adolescents are more at risk of sexual violence (Stein, Jaycox, Kataoka, Rhodes, & Vestal, 2003). In addition, the threat of physical abuse in boys is higher than in girls, but the latter have an increased risk of suffering maltreatment or sexual abuse (Krug, Mercy, Dahlberg, & Zwi, 2002; Ridge, 2011). Furthermore, researchers observed a deficit in dispositional empathy in parents who are at a high risk level of committing physical child abuse: they show fewer

feelings of warmth, compassion, and concern for others and more feelings of anxiety and discomfort as a result of observing another person's negative experience (Perez-Albeniz & de Paul, 2003).

Studies of primary and secondary prevention focus on manifold aspects of child sexual abuse, such as: The role of victim empathy and rape myths among high-risk males (Schewe & O'Donohue, 1993); empathy in sex offenders (Marshall, Hudson, Jones, & Fernandez, 1995); and rates of child sexual abuse through comparison between people who received a prevention program in school and those who did not (Gibson & Leitenberg, 2000; Yeater & O'Donohue, 1999). Current information on prevalence, risk factors, outcomes, treatment, and prevention of child sexual abuse is available (M. K. Davis & Gidycz, 2000), as well as studies about techniques for coping, although there is little examination on the effectiveness of these techniques in preventing abuse (Boudreaux, Catz, Ryan, Amaral-Melendez, & Brantley, 1995; Molnar, Buka, & Kessler, 2001; Wurtele & Miller-Perrin, 1993). Recent studies of web-based training for the prevention of child sexual abuse showed that these programs improved "knowledge and behavioral strategies" (Collin-Vézina, Daigneault, & Hébert, 2013, p. 5; Müller, Röder, & Fingerle, 2014, p. 61). However, there is no available research study about the relation between empathy and E-Learning programs for the prevention of child sexual abuse.

The Interpersonal Reactivity Index (IRI) is considered a classical outstanding empathy measure with four dimensions which distinguish the emotional and cognitive aspects of empathy. This scale has been shown to have good reliability, internal consistency and validity (Christopher, Owens, & Stecker, 1993; Davis, 1980; Davis, 1983; Hawk et al., 2013; Péloquin & Lafontaine, 2010). Spanish adaptation has showed similar results in relation to dimensionality, reliability, and concurrent validity in teenagers and college students (Hawk et al., 2013; Mestre Escrivá, Frías Navarro, & Samper García, 2004; Péloquin & Lafontaine, 2010). Other instruments such as the Toronto Empathy Scale which focuses on empathic concern (Cusi, MacQueen, Spreng, & McKinnon, 2011; Spreng et al., 2009) have been developed in recent years (Gerdes, Segal, & Lietz, 2010; Reniers, Corcoran, Drake, Shryane, & Völlm, 2011; Sawang et al., 2010; Spreng et al., 2009). Nevertheless, IRI was chosen on account of its ease of application, as well as its superiority for assessment of multidimensional empathy´s perspectives into its cognitive and emotional factors.

Scale score reliabilities were acceptable to good, ranging from .65 to .83 (Cronbach alpha coefficient) for the first assessment. Scale score reliabilities of the IRI subscales were similar to or greater than internal consistencies of the original version (from .72 to .78; Davis, 1980). All IRI subscales correlate positively with other variables like prosocial behavior and prosocial thinking styles (which are connected to a prosocial disposition) and correlate negatively with aggressive behavior and emotional instability (hedonistic reasoning more oriented to the search of personal benefit and other's approval).

The present study seeks to answer the following research questions: 1) Can empathy as a cognitive and affective capacity be improved? 2) Does the intervention of an E-Learning pilot program improve the level of empathy of participants?

METHOD

The experiment consisted of assessing change in the Situational and Dispositional Empathy scales within a child-care adults' group who followed an E-learning pilot program on prevention of child sexual abuse. The E-Learning curriculum offers five modules, with up to five learning units in each one. The structure of each unit is based upon a diary and upon the detection process of child sexual abuse cases with their respective tasks. The user follows a theoretical study and unique fictitious cases (one girl and two boys, based on experience) in order to always to repeat the same situation although focusing on different aspects or perspectives (Figure 1). At the end of each module the participants have to pass a multiple choice exam. The variables mentioned above were measured at the beginning of the program (T_1) and six months later (T_2) using the internal scales of the pilot program in contrast with a standardized questionnaire – that is, the Interpersonal Reactivity Index (IRI) of Mark H. Davis – adapted (without negative items) for the Spanish language.

Participants

Forty-two people enrolled and completed the training program. Therefore, this group constitutes the sample to assess the effect of the intervention (pre-test/post-test). Another 52 people initially enrolled through the institutional website and information center but soon abandoned the pilot program (dropout group). As shown later, no statistically-significant differences were found in any variable of the study after the analysis of both groups. Hence all 94 individuals were included in the psychometric analysis (Table 1). All

individuals were informed about the purpose of the study, were assured of confidentiality, and consented to participate.

Criteria for inclusion were: adult persons (i.e., minimum age 18 years old) who worked with or were in direct relationship with children and adolescents; had voluntarily completed the Interpersonal Reactivity Index (IRI) and had filled out the informed consent form and the program's initial questionnaire and scales. The criterion for exclusion was answering the empathy scale questionnaire (IRI); those who did not do so were excluded. The suspension criterion was the voluntary decision of participants to discontinue with the training pilot program and research.

Among the participants who continued with the pilot program were 33 women and nine men, aged between 24 and 69 years (M = 41.93 , *SD* 11.94 years). All of them were involved in activities with children and youngsters.

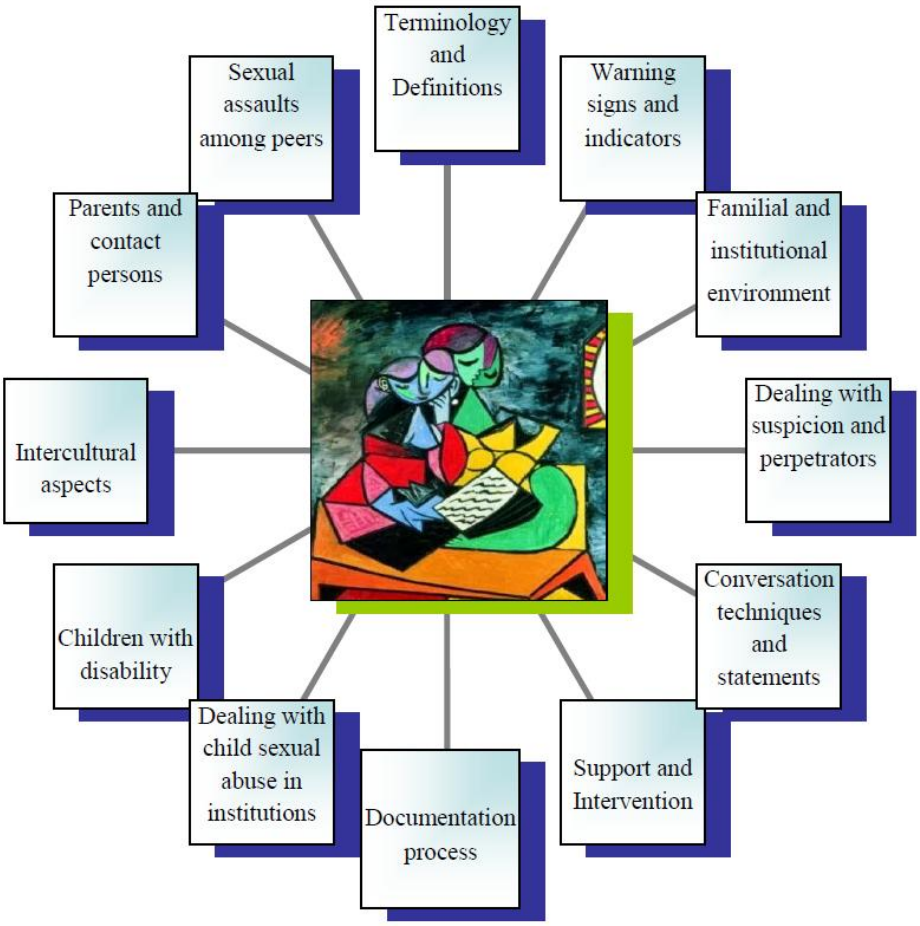

FIGURE 1 Intervention program with unique fictitious cases (one girl and two boys) that were based on experience and studied from different perspectives.

Measures

The present study focuses on dispositional and situational empathy, the latter measuring three dimensions: feeling, cognition, and readiness for action.

DISPOSITIONAL EMPATHY

The author's scale defines a multidimensional view of empathy as the reactions of one individual to the observed experiences of another (Davis, 1983). A questionnaire with 28-items

TABLE 1: Socio-demographic data of 94 interviewed participants

Variables	**Mean / %**
Age	44.5
Gender (%)	
Women	**82.98**
Dropout Group (DOG)	57.7
Analysis Group (AG)	42.3
Men	**17.02**
Dropout Group (DOG)	43.75
Analysis Group (AG)	56.25
Professional Activity (%)	
Pedagogical	33
Social Work	14
Psychological	13
Pastoral	15
Others	27
Access to children and youngsters (%)	
Regular contact through professional activities	91.5
Previous contact with affected minors	73.4
No contact with affected minors	26.6
Access to offenders (%)	
Previous contact with offenders	32
Without previous contact with perpetrators	68
Formation on Prevention of Sexual Abuse (%)	
Yes	37
No	63
Own Knowledge on Sexual Abuse	
• High level	14
• Mean level	28
• Low level	58
Personal capacity on professional interaction	
• High level	19
• Mean level	25
• Low level	56

Results are means or percentage of the respective socio-demographic variables. *Abbreviations:* CSA= Child Sexual Abuse, AG= Analysis Group, DOG= Dropout Group

answered on a 5-point Likert scale ranging from (1) *"does not describe me well"* to (5) *"describes me very well"* was developed. This self-report measure has four subscales like a set of separate constructs, each made up of seven different items, which take account of some specific aspect of a more general concept. To test the structure of the scale, a Confirmatory Factor Analytic (CFA) procedure was used with the LISREL 8.76 program. Finally, an adaptation of the Interpersonal Reactivity Index was employed in the Spanish version with 15 positive items (Appendix 1) after withdrawing the negatively oriented ones and other items that were inconsistent with their own subscales because they distort the dimensional structure proposed by the author (Salazar, 2015). The outcome was a good adjustment of the model (Chi-square=126.14, df=84, p =.0020, RMSEA=.071, CFI=.94, SRMR=.089).

The adapted version consists of the next four subscales, which are integrated into two pairs. The first pair is more focused on the cognitive area: the Perspective-Taking (PT) subscale, with three items (α= .73), estimates the tendency to spontaneously adopt the psychological point of view of others (e.g. *"I try to look at everybody's side of a disagreement before I make a decision"*); the Fantasy (FN) subscale, with five items (α=.82), taps respondents' tendencies to transpose themselves imaginatively into the feelings and actions of fictitious characters in books, movies, and plays (e.g. *"I really get involved with the feelings of the characters in a novel"*). The second pair assesses typical emotional reactions: the Empathic Concern (EC) subscale, with four items (α= .65), measures "other-oriented" feelings of warmth and compassion for unfortunate others (e.g. *"I often have tender, concerned feelings for people less fortunate than me"*); and the Personal Distress (PD) subscale, with three items (α= .75), values "self-oriented" feelings of personal anxiety (rather than other-oriented ones) and unease in intense interpersonal situations (e.g. *"In emergency situations, I feel apprehensive and ill-at-ease"*).

SITUATIONAL EMPATHY

Three scales proper to the prevention pilot program were considered: Situational Empathy with direct implication (SEDI), Situational Empathy without it (SEwDI), and Situational Coping (SCop).

SITUATIONAL EMPATHY WITH DIRECT IMPLICATION (SEDI)

As a measure of situational empathy, this scale focuses on a situation where someone is directly confronted with a problem and has an initial condition: *"If a member of my community confided a problem of child sexual abuse to me..."* The participants answered with a 5-point Likert scale ranging from (1) *"strongly disagree"* to (5) *"strongly agree."* A Confirmatory Factor Analytic (CFA) procedure was followed in order to test the structure of the scale (Spreng et al., 2009). The outcome was a good adjustment of the model (Chi-square= 33.47, df=24, *p*=.095, RMSEA=.071, CFI=.98, SRMR=.056).

The scale consists of nine items gathered into three dimensions: the first one is Anxiety/Anguish, with three items (α=.80), (e.g. *"I would feel apprehensive"*); the second group is Block, with four items (α=.77), (e.g. *"I would lose control of the situation"*); the third dimension is Inhibition, with two items (α=.74), (e.g. *"I would feel reluctant to discuss it with other persons"*).

SITUATIONAL EMPATHY WITHOUT DIRECT IMPLICATION (SEWDI)

This scale also measures situational empathy but focuses on a different perspective. In this case, someone is not confronted with a problem in a direct setting and the questionnaire begins with an initial condition: "*If I hear or read a report of child sexual abuse…"* The participants answered with a 5-point Likert scale ranging from (1) *"strongly disagree"* to (5) *"strongly agree."* The CFA analysis shows an acceptable adjustment of the model (Chi-square= 46.28, df=26, *p*=.0085, RMSEA=.093, CFI=.92, SRMR=.087).

SITUATIONAL COPING (SCOP)

Like the other subscales, SCop assesses another aspect of situational empathy, in order to respond to a difficult situation. It begins with an initial condition: "*If someone hints at a situation of child sexual abuse that makes me feel uncomfortable ..."* The participants answered with a 5-point Likert scale ranging from (1) *"strongly disagree"* to (5) *"strongly agree."* The scale consists of 14 items gathered into five dimensions: the first one is Religious Avoidance, with three items (α=.85); the second group is Narcissist Avoidance, with three items (α=.70); the third dimension is Religious Coping, with two items (α=.79); the fourth group is Avoidance, with three items (α=.66),; the fifth dimension is Coping, with two items (α=.64). One of the items was considered separately be-

cause of its special character of denial mechanism (i.e., *"I refuse to believe it"*). This item was more significant than the others and showed a great sensitivity to the intervention. The adjustment of the model by CFA was acceptable (Chi-square= 119.92, df=69, *p*=.00014 , RMSEA=.084, CFI=.91, SRMR=.084).

Data Analysis

Descriptive statistics, as well as analysis of variance (ANOVA), η^2 as effect-size index and first-order correlations were computed with the IBM SPSS Version 20.0 software. Confirmatory Factor Analytic (CFA) procedure was used to test the scales' dimensional structure with the LISREL 8.76 program: The Comparative Fit Index (CFI) as Fit indexes; the Root Mean Square Error of Approximation or RMSEA, adjusted by parsimony (Bentler, 1990; Brown, 2006; Kline, 2005) as incremental or comparative fit index; and the Standardized Root Mean Square Residual, as absolute fit index. Internal consistency is also provided from each one of the measures through Cronbach's alpha coefficient (α).

RESULTS

Dropout Group

Empathy measurement was compared after six months. Only 42 participants remained in the program until T_2, by which time 52 participants had already dropped out (most of them at the beginning due to difficulties in managing the system and internet access, and perhaps because such a program forces them to confront their own emotional experiences and personal fragilities). After the score's analysis of the group that remained in the program until T_2 (AG T_1) and the group that left after the first measurement (i.e., DOG T_1), no statistically significant difference in any of the variables of contrast used in the questionnaire were found (Table 2). Apparently the subjects that remain are no different from those who, for many extrinsic reasons, have left the program. These results are evidence of the balance or comparability of both groups.

Dispositional Empathy (IRI-Davis)

There were no statistically-significant differences in any of the four dimensions. Nevertheless, it is important to note that the Personal Distress subscale has a moderate ef-

fect size, $F(1, 41) = 1.99$, $p = .165$, $\eta^2 = .046$, even though these differences are not statistically significant. As shown in Table 3, there is a slight improvement in the expected direction. On the other hand, the dimension Empathic Concern (EC) presents almost none of the expected differences, probably due to the more emotional character of this dimension. Overall, one may conclude that the training pilot program did not have a significant effect on dispositional empathy, thus showing its stable character.

TABLE 2: Differences between AG (T_1) - DOG (T_1) in Situational and Dispositional Empathy and Coping Mechanisms.

Scales	***Subscales***	***Mean AG T_1***	***Mean DOG T_1***	***SD AG T_1***	***SD DOG T_1***	***F (1,41)***	***p***
Dispositional empathy (IRI)	Perspective Taking	3.60	3.39	.83	.91	1.36	,246
	Fantasy	2.23	2.00	.90	.77	1.71	.194
	Empathic Concern	2.86	3.08	.70	.78	2.00	.160
	Personal Distress	**2.06**	**1.92**	.80	.74	.70	.406
Situational empathy with direct implication	SEDI	**2.00**	**2.07**	.60	.79	.25	.615
	Anxiety	**2.37**	**2.29**	.97	1.05	.13	.718
	Block	**1.79**	**1.94**	.55	.85	1.07	.304
	Inhibition	1.88	2.02	.85	.95	.54	.463
Situational Empathy without direct implication	SEwDI +	4.01	3.82	.71	.79	1.54	.218
	SEwDI -	1.93	2.21	.68	.81	3.17	.079
Situational Coping SCop	Religious Avoidance	**1.75**	**1.78**	.67	.92	.03	.862
	Narcissist Avoidance	**2.10**	**2.05**	.64	.86	.07	.791
	Religious Coping	3.94	3.88	.72	1.08	.11	.737
	Avoidance	**2.36**	**2.56**	.87	1.00	1.12	.292
	Coping	**4.00**	**4.14**	.83	.84	.693	.407
	Denial	**4.07**	**3.81**	.89	1.12	1.54	.219

Abbreviations: IRI=Interpersonal Reactivity Index, T_1= pre test, AG= Analysis Group, DOG= Dropout Group, $N_{AG\ (T1)}$= 42, $N_{DOG\ (T1)}$= 52, SD = Standard Deviation, SEDI= Situational Empathy with direct implication, SEwDI= Situational Empathy without direct implication, SCop= Situational Coping.

Situational Empathy

The expected changes were consistent, especially in the scales related to a direct implication (SEDI) with the announced condition ("*If a member of my community confided a problem of child sexual abuse in me ...*"). The mean diminished in all the subscales (Table 3), even though in the Inhibition scale this evolution is neither significant nor relevant. On the other hand, a significant and important progress in empathic fields of Anxiety F (1, 41) =7.02, p =.011, η^2=.146 and Block F (1, 41) = 7.33, p = .010 , η^2=.152 was observed in consonance with the aims of the program. These changes had a significant value and reinforce the question about the possibility for someone to develop empathy when confronted directly with a problematic situation, in this case, child sexual abuse.

Furthermore, if the Situational Empathy measure uses a slogan with less implication ("*If I hear or read a report about child sexual abuse...*") the differences between T_1 and T_2 disappear. Hence, the two subscales of the program that measured Situational Empathy without direct implication (SEwDI), as shown in Table 3, do not alter these aspects. Regarding the Situational Coping Scale (SCop), as shown in Table 3, there were changes in the expected direction, except for the Religious Coping scale, which remained without significant change F (1, 41) = .60, p = .443 , η^2=.014. The most important and significant progress corresponds with Religious Avoidance F (1, 41) = 18.05, p < .000 , η^2=.306, and Avoidance F (1, 41) = 6.09, p = .018 , η^2=.13 *(p=.018, η^2=.129).* In the dimensions of Narcissist Avoidance F (1, 41) = 3.05, p = .09, η^2= .07 and Coping F (1, 41) = 1.57, p = .22, η^2= .04, relevant changes were observed, although they are not statistically significant.

The results collected with a single item that reflects the denial mechanism ("*I refuse to believe it"*) deserve special mention. As shown in Table 3, a major change is observed in the relevant persons F(1, 41) = 98.79, p < .000, η^2= .71, who evolve from a position of disbelief into a position of accepting the reality of the problem, one of the primary objectives of the prevention pilot program.

The data shows significant differences in most of the situational empathy scales. But, in the case of Dispositional empathy there are only significant differences in the Personal Distress subscale.

TABLE 3: Differences between pretest (T_1)/posttest (T_2) in Dispositional, Situational Empathy and Coping Mechanisms.

Scales	*Subscales*	*Mean T_1 SD T_1*	*Mean T_2 SD T_2*	*F (1,41)*	*df*	*Significance ρ*	*Partial η^2*
Dispositional Empathy (IRI)	Perspective Taking	3.60±.83	3.69±.83	.32	1	.574	.008
	Fantasy	2.23±.90	2.31±.93	.63	1	.431	.015
	Empathic Concern	2.86±.70	2.88±.90	.01	1	.905	.000
	Personal Distress	**2.06**±.80	**1.91**±.59	**1.99**	1	**.165**	**.046**
Situational Empathy with direct implication SEDI	SEDI	**2.00**±.60	**1.78**±.50	**9.57**	1	**.004**	**.189**
	Anxiety	**2.37**±.98	**2.02**±.72	**7.02**	1	**.011**	**.146**
	Block	**1.79**±.55	**1.56**±.48	**7.33**	1	**.010**	**.152**
	Inhibition	1.88±.85	1.83±.68	.15	1	.697	.004
Situational Empathy without direct implication SEwDI	SEwDI +	4.01±.71	4.01±.60	**.003**	1	**.958**	**.000**
	SEwDI -	1.93±.68	1.89±.54	**.198**	1	**.659**	**.005**
Situational Coping SCop	Religious Avoid.	**1.75**±.67	**1.29**±.50	**18.05**	1	**.000**	**.306**
	Narcissist Avoid.	**2.09**±.64	**1.93**±.61	**3.05**	1	**.088**	**.069**
	Religious Coping	3.94±.72	4.02±.73	.60	1	.443	.014
	Avoidance	**2.36**±.87	**2.16**±.85	**6.09**	1	**.018**	**.129**
	Coping	**4.00**±.83	**4.15**±.60	**1.57**	1	**.217**	**.037**
	Denial	**4.07**±.89	**1.76**±.98	**98.79**	1	**.000**	**.707**

Abbreviations: IRI=Interpersonal Reactivity Index, T_1= at the beginning, T_2= after six months, F= Fischer contrast test in ANOVA, df= degrees of freedom, Sign (*p*-value)= Significance, Partial η^2= Effect size, N= Number of Cases.

DISCUSSION

People who are in permanent contact with children and adolescents (i.e., parents, teachers, psychologists, social workers) are particularly important to their development and are one of the main resources in the prevention of child sexual abuse—obviously an important goal. The current study used a pre-test/post-test design to examine changes in dis-

positional and situational empathy following participation in a six-month on-line training pilot program aimed at preventing sexual abuse of children.

1) Improvement of empathy: The approach followed in this work integrates feeling, cognition, and readiness to action. Empathy is considered as the art of understanding someone else's mental and emotional state, in order to comprehend it "as if" it were experienced in oneself. Crucial elements such as affective sharing, emotional regulation, perspective-taking, fantasy, empathic concern, personal distress, coping, and disposition (among others) are involved and place one in the moment of discernment and action.

In the social neurosciences, researchers propose that "continuous social interaction should produce noticeable effects on empathic abilities of an individual independent of age or level of brain maturation" (Georgi, Petermann, & Schipper, 2014, p. 75). After the bibliographical review, the analyses of some scales (results showed improvement in 2 of the 3 subscales of a measure called Situational Empathy with Direct Implications (SEDI) from pre-test to post-test), and observation of participants in the internet-based prevention pilot program of child sexual abuse, it is plausible to concur with other authors who maintain that it is possible to learn and improve empathy. What this study adds to the current discussion is that empathy is not just a matter of how someone can understand another´s emotions or a good disposition toward the needs of a person, but rather also depends on the implication level in a specific situation, such as, in this case, child sexual abuse. In other words, an individual´s dispositional empathy is not by itself enough, nor a warranty of being an empathic person. The most important factors are the professional experience and the process of learning and improving empathic abilities.

2) Impact of E-Learning: The prevention pilot program offers not only a theoretical study through academic documents, but also case analyses alongside individual and group supervision with profound knowledge about prevention. Each module studies a different perspective of the problem with simulated cases (one girl and two boys) to repeat the situation although focusing on different aspects. The program was in the initial pilot phase and should lead to prevention work with children and others in the family circle. Hence, working with adults who are in contact with children was a good way to observe the support method and empathetic reaction that facilitate improvement in prevention.

Many commentaries from participants show a greater level of involvement in prevention of child sexual abuse: "*I will consider in the future, that if I want things to be dif-*

ferent, I should act and speak during my time living in the institution and not after my withdrawal from it;" "I will note that it is very important to distinguish between facts and my assumptions."

These observations are consistent with the stability of the Davis scale that measures dispositional empathy in its cognitive (PT, FN) and emotional (EC, PD) aspects (Perez-Albeniz & de Paul, 2004). Empathy scales do not experience a significant improvement. However, the Personal Distress (PD) subscale shows a significant decrease F (1,41)= 1.99, p= .165, η^2= .046. This result fails to be statistically significant. The lack of statistical significance may be due to a small sample size. Perhaps the prevention pilot program also reduces discomfort generated by the proximity of a situation of child sexual abuse. That is also the case with denial as a coping mechanism, which has outstanding significance, perhaps due to an increasing sensitivity that brings better acceptance of the topic and less personal distress. In the dependent variables of cognitive dimension a slight improvement was also observed, but not in the Empathic Concern (EC) subscale, which remains virtually unchanged.

Limitations

A major limitation of this pilot study is the lack of the control group. However, the research followed a single group pre-test/post-test design. The social-intervention nature of this project, as well as the voluntary participation in it, implies a limited applicability of randomized controlled experimental designs (Stufflebeam & Coryn, 2014) (Stufflebeam & Coryn, 2014). In particular, it is not possible to establish a control group because of the need to have, in the short-term, trained child-care professionals including teachers, day care providers, clergy, and coaches (Rheingold, Zajac, & Patton, 2012). Moreover, it is not feasible to withdraw professionals from training processes who have volunteered to receive such a program, but who would hardly agree to participate simply as controls. However, the dropout group itself could be taken as a quasi-control group because it does not complete the whole program. Future studies should evaluate the effectiveness of this approach.

Furthermore, the professional field of people who are in contact with minors is unbalanced concerning gender, as these are feminized professions (Lorente Molina, 2004) and women show a higher empathic abilities than male colleagues (Reniers, Corcoran,

Drake, Shryane, & Völlm, 2011). Further research should include a sample in which more male subjects will participate.

The gender comparison in our data lacks statistical power due to the small size of the male sample (N=9). The effectiveness of the pilot program in preventing sexual abuse has not yet been fully assessed. Nevertheless, the results suggest it would be valuable to continue this line of research.

There are still many questions to be clarified, such as the denial mechanism as a culturally specific defensive style, and the need for implementing a more integral approach in the formation of relevant adults in order to improve prevention of child sexual abuse.

Conclusion

This research has attempted to address questions regarding empathy and the prevention of sexual abuse against children and youngsters. Empathy shows the importance of being connected with people who live in a vulnerable world. Recognition of one's own weaknesses is a part of the learning process regarding how to improve empathic abilities according to the needs of people in specific situational contexts, like the prevention of child sexual abuse. This is one way of becoming people with a high sense of self-worth who are able to show mercy to others as well as receive it. Thus they can resolve conflicts with gratitude and joy.

ACKNOWLEDGEMENT

The authors gratefully acknowledge support from their own and Universities. We used as the main tool the Moodle platform of the Centre for Child Protection of the Pontifical Gregorian University in Rome. Both the logistic support as well as the study sample data (survey of anonymous responses) were provided by the Archdiocese of Munich & Freising in cooperation with the Department of Child and Adolescent Psychiatry and Psychotherapy at Ulm University Medical Center (both are cooperation partners of the Centre for Child Protection of the Pontifical Gregorian University), and Soon-Systems Ltd. (Specialist Expertise E-Learning). This pilot program (Prevention of Child Sexual Abuse for Pastoral Professions) draws on a related public-sponsored program for educational and health-care professionals in the German Federal Ministry for Education and Research (BMBF). To get the sample to be studied, we used the virtual training pilot programme for

professionals of a Pedagogical Initiative in the International Federation Fe y Alegría, whose goal is to offer the benefit of a high quality education to children and adolescents living in poverty and risk conditions in Latin America, Africa, and Italy.

APPENDIX 1: Positive Items in Spanish from IRI - Davis by subscales)

IRI Subscale	Items
Perspective Taking (PT)	8. Intento tener en cuenta cada una de las partes (opiniones) en un conflicto antes de tomar una decisión. 11. A menudo intento comprender mejor a mis amigos(as) imaginándome cómo ven ellos(as) las cosas (poniéndome en su lugar). 21. Pienso que hay dos partes para cada cuestión e intento tener en cuenta ambas partes.
Fantasy (FS)	1. Sueño y fantaseo, bastante a menudo, acerca de las cosas que me podrían suceder. 5. Verdaderamente me identifico con los sentimientos de los personajes de una novela. 16 . Después de ver una obra de teatro o cine me he sentido como si fuera uno de los personajes. 23. Cuando veo una buena película puedo muy fácilmente situarme en el lugar del protagonista. 26. Cuando estoy leyendo una historia interesante o una novela imagino cómo me sentiría si los acontecimientos de la historia me sucedieran a mí.
Empathic Concern (EC)	2. A menudo tengo sentimientos tiernos y de preocupación hacia la gente menos afortunada que yo. 9. Cuando veo que a alguien se le toma el pelo tiendo a protegerlo(a). 20. A menudo estoy bastante afectado(a) emocionalmente por cosas que veo que ocurren. 22. Me describiría como una persona bastante sensible.
Personal Distress (PD)	6. En situaciones de emergencia me siento aprensivo(a) e incómodo(a). 10. Normalmente siento desesperanza cuando estoy en medio de una situación muy emotiva. 17. Cuando estoy en una situación emocionalmente tensa me asusto.

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Zweiter Artikel

Coping Mechanisms for Psychosomatic Symptoms among Aging Roman Catholic German priests

Journal of Religion and Health, 2018

ISSN 0022-4197 (print) 1573-6571 (online)
https://doi.org/10.1007/s10943-018-0582-6

Coping Mechanisms for Psychosomatic Symptoms among Aging Roman Catholic German priests

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To identify and investigate coping mechanisms and other factors which may impact upon the psychosomatic symptoms of aging German Roman Catholic priests. A cross-sectional study was conducted among 499 aging German Roman Catholic priests with standardized questionnaires: Brief Symptom Inventory, Coping Inventory Stressful Situations, and Religious Coping Scale. Task-Oriented Coping exhibited a significant difference between the two groups. Multiple regression analyses indicated that psychosomatic symptoms could be best predicted by means of Task-Oriented Coping mechanisms, identification with priesthood, and by a low Negative Religious Coping. The success of adaptive coping processes for older clergy may depend on how they employ strategies, strengthen their spiritual dimensions, and manage important psychosocial aspects of aging. In our sample, Depression and Somatization are explained best by Emotion-Oriented Coping. It is desirable for aging priests to be aware of protective factors like Role Identification, Task-Oriented Coping, and low Negative Religious Coping, which may be helpful in improving their psychological well-being.

Keywords: Aging priests, Psychosomatic symptoms, Depressive symptoms, Coping mechanisms, Religious coping

Received 01.01.2017; revised 9.8.2017; accepted 7.2.2018; published online 14.2.2018.

INTRODUCTION

Aging German Roman Catholic priests continue working in many parishes and other ministries across Germany even after retirement. They may have to balance manifold changes related to retirement and age, for example, regarding health, social position, new living arrangements and neighborhoods, experiences of loss, and extended leisure time.

A successful aging process requires acceptance and flexibility in facing new conditions of life and health, as well as the achievement of personal goals (Baltes and Mayer 2001; Sowa et al. 2016). Yet, people are seldom prepared psychologically for retirement or for other stressful life-changing events (Lazarus and DeLongis 1983), e.g., life-threatening illnesses like cancer or cardiac dysfunction (Carels 2004). Risk of mental disorders increases in older age, especially of depression. In the case of aging German Roman Catholic priests, retirement, changing social relationships, a decrease of personal competencies, and loss of relatives, friends, and colleagues are among the main challenges they face during their later years. In addition, this particular group of priests may intensify their spiritual needs as they grow older and their leadership and activities decline (Ardelt and Koenig 2006; Bono and McCullough 2004, Coleman 2011, Man-Ging 2015). Older people who live alone—not only priests—may frequently experience states of anxiety or even phases of reactive depression (Alexander 2001; Cacioppo et al. 2006, Montesó et al. 2012). There are several studies, with various focuses of interest, about depression and anxiety in groups of clerics (Abdelsayed et al. 2013; Doolittle 2007; Francis and Rutledge 2004;
Isacco et al. 2015; Knox et al. 2005; Lewis et al. 2007; Plante and Aldridge 2005; Thomas and Plante 2015). However, there is little research about how older priests' coping may influence their psychosomatic and depressive symptoms.

Coping is a dynamic process that is activated in stressful situations. It encompasses flexibility in order to regulate negative emotions and to balance assimilation and accommodation (Brandtstädter 2009). Researchers distinguish different coping mechanisms (Golden 1982; Murberg and Bru 2001) and organize them into different perspectives and models: problem- and emotion-focused coping (Lazarus and DeLongis 1983); a dual process framework of assimilative and accommodative modes (Brandtstädter and Rothermund 2002); Task-, Emotion-, Avoidance-Oriented Coping (Endler and Parker 1990); selective optimization with compensation (Ouwehand et al. 2007; Baltes et al. 2011), among others.

We chose to use the Task-, Emotion-, Avoidance-Oriented Coping model, i.e., Coping Inventory Stressful Situations (CISS), based on previous research (Paez et al. 1995; Klein et al. 2007; Orgeta and Orrell 2014) in order to analyze coping of aging German Roman Catholic priests (Frick et al. 2016). We gave special attention to the role of emotions (Austenfeld and Stanton 2004; Blanchard-Fields 2007; Marcks and Woods 2005; Petrie et al. 1998) and perception of success and failure in life (Kane and Jacobs 2015b). Previous studies and meta-analyses have found that task coping is positively related to mental health, while Emotional Coping is negatively related (Penley et al. 2002; Campos et al. 2004). A review of over 100 studies found associations between emotion-focused coping and depressive and anxious symptoms (Austenfeld and Stanton 2004). Also, avoidant coping was related to symptomatology in a meta-analysis (Aldao et al. 2010). We expected that Task Coping will be negatively, while Emotion- and Avoidance-Oriented Coping will be positively related to depressive, anxious, and somatic symptoms.

We assume that priests widely use elements of Religious coping (RC). RC shows the degree to which a person can find strength, control, and support in times of stress or traumatic events thanks to the use of religious resources which may be cognitive, emotional, behavioral, and social (prayer, rituals, joy, hope, and reconciliation, and models of interpretation in connection with health (Lewis et al. 2005; Pargament et al. 2005; Frick et al. 2016; Büssing et al. 2017b). Several studies show a different relationship of wellbeing with positive and negative RC. Basically, positive RC is trust oriented in relation to God, while negative RC stresses doubt, disappointment, and complaint. Additionally, a positive RC was to be linked to better mental health. Conversely, a negative Religious Coping style was related to low physical health and higher levels of depression. Longitudinal investigations have shown that an increased spiritual questioning at the onset of a negative experience is a predictor of a significant increase in the indexes of psychological disorders over time (Pargament et al. 2004). In the studies of Harris et al. (2012) and (García et al. 2014), negative RC showed a longstanding, significant positive relationship with symptoms. On the other hand, positive RC did not show any relationship with stress symptoms but predicted a positive outcome like posttraumatic growth (Rajandram et al. 2011; Gerber et al. 2011). We included the RC Scale in our research and expected that negative RC would be related to symptoms.

Conceptually, we want to stress that ‘‘negative’’ elements such as struggling, doubting, and lamenting may nevertheless be part of a vivid and helpful spiritual process in the long run. The concept of struggle is quite prominent in the biblical, in the Jewish tradition, for example, in the narratives of Jacob and Job. These narratives show that struggle may be a necessary ingredient or process in growth and change. While research in this field is still an ongoing task (King et al. 2017), clinicians have to ‘‘discern when struggle is in fact problematic and potentially deadly and when people are taking a more constructive, healthy path through their struggle. […]. These struggles are not necessarily a problem. Sometimes they propel us forward in our lives’’ (Pargament et al. 2011). The experience of religious struggle may be related to spiritual dryness, which necessitates discernment of relevant dynamics (Exline et al. 2014; Büssing et al. 2017a).

Aim/Questions

The present study aims at addressing the following research questions: (1) Is there a relationship between coping mechanisms and depressive symptoms in aging German Roman Catholic priests? (2) Which variables of coping and priestly identity are protective factors for their psychological well-being?

Methods

Sample

A total of 8.574 individuals (4.157 priests) accepted to participate in this anonymous crosssectional study, which is part of the German Pastoral Ministry Study (Frick et al. 2016). They were informed through an invitation letter about the purpose of the research and were assured confidentiality. The collected data were assigned anonymous codes. The whole study was approved by the Ethics Committee of the Munich School of Philosophy.

Inclusion criteria for this part of the research were (1) being a German Roman Catholic priest and (2) being at least 65 years old (1933 individuals). In the general German population, this is a usual age of retirement. For the present part of the research, we included questionnaire modules which were added for 10/22 German dioceses. Consequently, we excluded questionnaires which did not encompass the added questionnaire modules.

Precisely, out of 1933 elderly participants, there remained a total of 499 with fully completed questionnaires. All relevant socio-demographic data are detailed in Table 1.

Table 1: Socio-demographic data of 499 survey respondents.

Variables	**(A) >65-75**	**(B) >75-85**
Age	49.5% (247)	50.5% (252)
German nationality	94	95
Printed questionnaire	96	99
Belonging to a		
…diocese/archdiocese	84.84	83.47
…religious order or community	15.16	16.53
Relationships		
Belonging to a group of priests who meet regularly	29.09	33.19
Regular spiritual exchange among priests	48.98	47.97
Priest's role identification	83.8	85.8
Way of living		
…alone	28.7	25.8
…alone with an assistant woman	27.1	15.8
…in the same household with a housekeeper	17.8	27.3
…with other priests in a house but in separate apartments	6.8	2.7
… in a residential community with other priests	6.8	6.3
… in a shared flat with other people (e.g. family)	4.8	7.1
… in a house for priests or (retirement home)	2.8	6.3
… other	4.8	7.9
Work (hours / week)		
less than 10 hours	8.1	15.6
from 10 to 20 hours	18.8	30.4
from 20 to 30 hours	10.3	19.6
from 30 to 40 hours	12.01	16.9
from 40 to 50 hours	15.5	9.8
from 50 to 60 hours	19.7	6.7
from 60 to 70 hours	9.9	.5
more than 70 hours	5.6	.5
Priests' Ministry		
Senior parish priest	27.53	1.58
Parish Vicar (cooperator)	8.09	3.57
Specific pastoral ministry	11.74	2.77
Diocesan assignment/position	6.48	11.51
Retirement	35.22	75.89
Other	10.93	3.97

Notes: Results are % of the totality of two groups of participants, Group A= 247 and Group B= 252 priests.

Measures

Brief Symptom Inventory (BSI)

This scale is a self-report designed to screen psychological distress, psychosomatic impairment of health, and psychiatric disorders (Derogatis 2001). Respondents rated their level of distress during the past week on each of the 18 symptoms using a 5-point Likerttype scale ranging from disagreement to agreement: 0 (not at all) to 4 (extremely). The scale assesses three symptom dimensions: Somatization (6 items), Depression (6 items), and Anxiety (6 items). Internal consistency–reliability estimates were derived from the community sample. Alpha coefficients for the three symptom dimensions were very satisfactory: .79 (Somatization), .80 (Depression), and .81 (Anxiety).

Coping Inventory Stressful Situations (CISS)

This inventory (48 items, using 5-point Likert scales from not at all to very much) explores the level of engagement in each different activity when interviewees encounter a difficult or upsetting situation. The instrument measures the three main strategies of Task-, Emotion-, and Avoidance-Oriented Coping (Endler and Parker 1990). Task-Oriented Coping involves dealing with the problem at hand (Boycott et al. 2015), restructuring it cognitively, and attempting to alter the situation: I will focus on the problem and see how I can solve it. In Emotion-Oriented Coping, emotional responses are self-oriented (e.g., one blames oneself, gets angry, or becomes upset), and in some cases, the reaction increases stress as one concentrates on the resulting emotions of anger or blame: I blame myself for not knowing what to do. Avoidance-Oriented Coping describes activities and cognitive attempts to avoid the problem: I will spend time with a special person. This third dimension of coping is divided further into two types: a 4-item Distraction subscale measures how one attempts to forget the problem (e.g., by phoning a friend), while a 3-item Social Diversion subscale quantifies one's engagement in pleasant activities in order to relieve the resulting stress (e.g., by shopping for leisure). We used a reduced version with seven items for each coping strategy. After removing two items (1 [Take some time off and get away from the situation], 17 [Wish that I could change what had happened or how I felt]), which distort the reliability from Avoidance and Task subscales, the outcomes were moderately positive with Cronbach's Alphas being .72 (Avoidance), .75 (Emotion), .76 (Task).

Religious Coping Scale (RCOPE)

This brief questionnaire is a 14-item reliable and valid measure of Religious Coping in the process of dealing with major life stressors, for example, crisis, trauma, and transition (Pargament et al. 2011). Items are organized on two subscales with a good standard of reliability: Positive RCOPE= .80 (e.g., Sought God's love and care, Tried to see how God might be trying to strengthen me in this situation, Asked forgiveness for my sins) and negative RCOPE= .76 (e.g., Wondered whether God had abandoned me, Wondered whether my church had abandoned me, Felt punished by God for my lack of devotion). Three items were removed because they distort the reliability of both subscales: one positive, Looked for a stronger connection with God (8) and two negative, that is, Questioned God's love for me (4), and Questioned the power of God (7).

Identification with Priestly Role (RI)

This is a numeric scale that interviewed priests had answered from 1 up to 5 to the question How strongly do you identify with your life as a priest?

Statistics

Descriptive statistics as well as analyses of variance, first-order correlations, and multiple regression analyses were computed with the Statistical Package for Social Sciences (SPSS), version 20.0. We established the significance level at p\.05.

Results

Description of the Sample

Participants with this version of the questionnaire were recruited in ten dioceses (84%) and in Catholic Religious Orders (16%) across Germany. They were divided into two agegroups (A = 65–74 and B = 75–85 years). The purpose of this classification was to know and to understand which strategies are used by aging German Roman Catholic priests in different age-groups and situations, such as work, retirement, belonging to a group, continuing habits like smoking and alcohol consumption, living alone or with company, among others.

As shown in Table 1, a total of 499 enrolled subjects were mostly German citizens (95%) living alone (A = 56%; B = 41%). Almost a third belonged to a group of priests who

met regularly (A = 29%; B = 33%), and almost half of them had regular spiritual conversations (A = 49%; B = 48%). Both age-groups showed a high percentage of identification with their role as priests (A = 84%; B = 85%). A third of the younger group and more than three-quarters of the older group were in retirement (A = 35%; B = 76%), but many of them still worked 10–30 h per week. Of those still active, few in the younger group and scarcely any in the older group still led their parishes (A = 28%; B = 1.6%). A slightly larger percentage of the older group, however, still held diocesan-administrative assignments (A = 6.5%; B = 11.5%). Not surprisingly, considering the participants' age, many of them had health concerns: hypertension problems (A = 52%; B = 54%), diabetes (A = 20%; B = 17.5%), obesity (A = 25%; B = 21.7%); about 55% regularly consumed alcohol, and 10% were smokers.

Table 2 presents means with standard deviations by age-groups for all variables. Task- Oriented Coping exhibited a significant yet only slight difference between the two groups of older priests (A = 3.63; B = 3.49; F = 5.22; p = .023). Another subscale, Somatization (A = 54.43; B = 56.25; F = 3.23; p = .073), showed a tendency toward significance, while the Religious Coping Scale (both positive and negative) revealed no significant differences.

Table 2: Differences by Age and Variables with Mean and Standard Deviation.

VARIABLES	**(A) >65-75**			**(B) >75-85**			**Total**			**ANOVA**		
	N	Mean	SD	N	Mean	SD	N	Mean	SD	df	F	Sign
BSI_Depr	247	54.49	10.69	251	54.80	10.33	498	54.65	10.50	1	.109	.742
BSI_Som	247	54.43	11.59	251	56.25	11.03	498	55.35	11.34	1	3.22	.073
BSI_Anx	247	52.80	10.37	250	51.81	11.15	497	52.30	10.77	1	1.04	.308
Identification	242	4.19	.89	249	4.29	.82	491	4.24	.86	1	1.64	.201
CISS_Avoidance	242	2.47	.85	241	2.49	.88	483	2.49	.87	1	.057	.812
CISS_Task	245	**3.63**	.65	248	**3.49**	.71	493	**3.56**	.68	1	**5.22**	**.023**
CISS_Emotion	240	2.45	.78	242	2.37	.77	482	2.41	.78	1	1.22	.269
RCOPE_Pos	237	2.98	.48	238	3.04	.51	475	3.01	.50	1	.004	.190
RCOPE_Neg	237	1.50	.52	239	1.45	.49	476	1.47	.50	1	1.30	.255

Significant variables were highlighted in bold

Abbreviations: BSI_Depr= Depression, BSI_Som= Somatization, BSI_Anx= Anxiety, CISS= Coping Inventory Stressful Situations Scale, RC_Pos= Religious Coping positive items, RC_Neg= Religious Coping negative items,SD= Standard Deviation, N= Number of cases, df= degrees of freedom, F= Fischer contrast test in ANOVA, Sign (*p*-value)= Significance.

Correlations Between Symptom Dimensions (BSI) and Psychological Health Predictors (Age, Identification, CISS, and RCOPE)

Emotion-Oriented Coping (CISS_Emotion) correlates positively with BSI_Depr, BSI_Som and with BSI_Anx). Z comparisons of correlations (Steiger 1980) between Emotion-Oriented Coping and anxiety with Emotion-Oriented Coping and somatic symptoms showed that the first association was stronger than the second, z = 19.47, p\.001 (data not shown). A similar result was found comparing Emotional Coping associated with depression and with somatic symptoms, z = 19.36, p\.0001. Moreover, the negative RC subscale positively correlates with these indicators while positive RC does not (correlation with CISS emotion is negligible). Analysis within psychological health predictors shows that negative RC correlates with Emotion-Oriented Coping, weakly with Avoidance-Oriented Coping as well as weakly negatively with Priests' role identification . In contrast, the positive RC subscale correlates positively with priests' role identification and negligibly with Task-Oriented Coping. Priests' role identification and BSI_Depr correlate moderately negatively (see Table 3).

Predictors of Psychosomatic Symptoms

Since we empirically investigated several variables that could interact with the respective indicators of psychosomatic symptoms (Windgassen et al. 2016), multiple regression analyses were performed to identify the most significant predictors (Table 4). Stepwise regression analyses included the following variables: Age, Identification with Priesthood, Coping Inventory Stressful Situations (Task-, Emotion-, and Avoidance-Oriented Coping), and RC. Following the tradition of studies on stress and coping (i.e., Nolen-Hoeksema and Aldao 2011), we propose that forms or styles of dealing with negatives events and related mood and emotions are the explanatory variables that predict well-being or (low) psychosomatic symptoms. Of course, it is possible that current affective states influence how people cope with stress. Because we did not have longitudinal data, it is impossible to disentangle antecedents and consequents in our study. However, multiple

regression (data not shown) of coping dimensions on symptoms and other psychosocial variables (identification and so on) as predictors explain less variance than multiple regressions described in this article. These results suggest that our data favor a model in which coping styles are the predictors and psychosomatic health the predicted variable.

Table 3: Correlations between symptom dimensions (BSI) and potential psychological health predictors (Age, Identification, CISS, and RC).

	Pearson	BSI_Depr	BSI_Som	BSI_Anx	RCP_Pos	RCP_Neg
Age	*r*	.010	.076	-.046	.063	-.052
Identification	*r*	**-.307****	-.126**	-.190	**.400****	**-.222****
CISS_Avoidance	*r*	.139**	.085	.139**	.064	**.196****
CISS_Task	*r*	-.136**	-.068	-.074	**.171****	-.089
CISS_Emotion	*r*	**.495****	**.319****	**.501****	.104*	**.315****
RC_Pos	*r*	-.088	.020	.039	N/A	N/A
RC_Neg	*r*	**.392****	**.213****	**.321****	N/A	N/A

Significant variables were highlighted in bold
Abbreviations: BSI_Depr= Depression, BSI_Som= Somatization, BSI_Anx= Anxiety, CISS= Coping Inventory Stressful Situations Scale, RC_Pos= Religious Coping positive items, RC_Neg= Religious Coping negative items, N/A= not applicable.
*: p <.05 two-tailed sig.**: p <.01 two-tailed sig.

In Table 4, Model 1 shows the results with BSI subscales as dependent variables with some predictors like Age, Priests' role identification, and Coping. 34% of depressive symptoms variance (BSI_Depr) was explained by low Identification (Beta = - .232, p\.001), low Task-Oriented Coping (Beta = - .164, p\.001), and high Emotion- Oriented Coping (Beta = .470, p\.001). Similarly, 29% of anxiety symptoms (BSI_Anx) variance was explained by Emotion-Oriented Coping (Beta = .490; p\.001), low Identification (Beta = - .127; p = .002), and low Task-Oriented Coping (Beta = -.102, p = .012). Finally, only 13% of somatization (BSI_Som) variance was explained by Emotion-Oriented Coping (Beta = .317, p\.001). The indicator of anxiety symptoms (BSI_Anx, R2 = .29; adj. R2 = .28) was predicted by Emotion-Oriented Coping (Beta = .490; p\.001), and low Identification (Beta = - .127; p = .002), and Task- Oriented Coping (Beta = -.102, p = .012). In Model 2, RC was included. However, model 2 does not have a higher predictive power than factors in Model 1.

Table 4: Multiple regression analyses with BSI sub-scales as dependent variables.

	Model 1			Model 2		
Variables and Predictors	***Beta***	***T***	***P***	***Beta***	***T***	***p***
Dependent variable: BSI_Depr	**R^2 = .340 (adj. R^2 = .332)**			**R^2 = .374 (adj. R^2 = .364)**		
(Constant)		17.973	.000		14.179	.000
Age	.036	.935	.350	.047	1.233	.218
Role Identification	**-.232**	**-.5971**	**.000**	**-.196**	**-4.684**	**.000**
CISS_Avoidance	.068	1.747	.181	.037	.952	.342
CISS_Task	**-.164**	**-4.196**	**.000**	**-.139**	**-3.600**	**.000**
CISS_Emotion	**.470**	**12.025**	**.000**	**.415**	**10.276**	**.000**
RC_Pos				-.009	-.209	.835
RC_Neg				**.202**	**4.938**	**.000**
Dependent variable: BSI_Som	R^2 = .133 (adj. R^2 = .123)			R^2 = .142 (adj. R^2 = .129)		
(Constant)		13.024	.000		10.211	.000
Age	.102	2.308	.021	.104	2.366	.018
Role Identification	-.095	-2.118	.035	-.095	-1.939	.053
CISS_Avoidance	.035	.781	.435	.016	.362	.717
CISS_Task	-.071	-1.590	.113	-.064	-1.421	.156
CISS_Emotion	**.317**	**7.068**	**.000**	**.282**	**5.967**	**.000**
RC_Pos				.042	.864	.388
RC_Neg				.103	2.148	.032
Dependent variable: BSI_Anx	**R^2 = .290 (adj. R^2 = .282)**			**R^2 = .312 (adj. R^2 = .301)**		
(Constant)		13.968	.000		10.376	.000
Age	-.030	-.757	.450	-.027	-.676	.499
Role Identification	**-.127**	**-3.138**	**.002**	**-.132**	**-3.008**	**.003**
CISS_Avoidance	.055	1.370	.171	.028	.684	.494
CISS_Task	**-.102**	**-2.517**	**.012**	**-.093**	**-2.289**	**.023**
CISS_Emotion	**.490**	**12.074**	**.000**	**.437**	**10.324**	**.000**
RC_Pos				.073	1.669	.096
RC_Neg				**.152**	**3.526**	**.000**

Abbreviations: BSI_Depr= Depression, BSI_Som= Somatization, BSI_Anx= Anxiety, CISS= Coping Inventory Stressful Situations Scale, RC_Pos= Religious Coping positive items, RC_Neg= Religious Coping negative items, ANOVA= Analysis of variance, Sign (*p*-value)= Significance. Significant variables were highlighted (bold). In all cases, the Tolerance Factor was > .80, indicating that collinearity was not present in the respective models.

Because multiple regression coefficients may be compromised by collinearity, we checked the Tolerance Factor as an indicator for collinearity. A tolerance of less than 0.25 indicates a multi-collinearity problem (O'Brien 2007). In all cases, the Tolerance Factor was[.80, indicating that collinearity was not present in the respective models.

Discussion

The present study is looking for answers to the following questions: (1) Is there a relationship between coping mechanisms and depressive symptoms in aging German Ro-

man Catholic priests like the associations found in previous studies, which means a negative association with direct or task coping and a positive with Emotional, Avoidant, and Negative RV? (2) Which variables are protective factors for their psychological wellbeing?

Our results are congruent with previous studies and meta-analyses: Direct or task coping is related to low symptom burden and Emotional Coping is positively associated with depression, anxiety, and somatization (Penley et al. 2002; Campos et al. 2004). According to these studies, higher Task-Oriented Coping is associated with lower depression (Carels 2004). This positive form of coping was a significant predictor of lower depressive and anxious symptomatology.

Emotion-Oriented Coping is the most important correlate and predictor of depression, anxiety, and somatization. This suggests an important role of Emotion-Oriented Coping in the psychosomatic symptomatology of aging German Roman Catholic priests. A maladaptive regulation of emotions might lead to anxiety, somatization, and depression. That is the case, for example, when a person suppresses emotional thoughts in order to regulate mood and reduce distress. Even though some authors reclaim the positive effect of controlling emotions (Austenfeld and Stanton 2004; Blanchard-Fields 2007; Desbordes et al. 2012), the research points out its collateral effect with an immunological response and dysfunctional outcomes (Marcks and Woods 2005; Petrie et al. 1998). A review of over 100 studies found associations between emotion-focused coping and higher depressive and anxious symptom burden (Austenfeld and Stanton 2004).

RC may influence mental health and intrinsic religious motivation through spiritually based activities or reliance upon a loving relationship with God and/or with the sacred (Pargament et al. 2006). As far as RC in our sample is concerned, positive RC subscale did not correlate with psychosomatic symptoms. It is possible that positive RC is associated only with positive psychological well-being. Negative RC correlates moderately with depression and anxiety symptoms. Other studies show similar findings: Negative RC is related to symptom burden (García et al. 2014), probably because it may be a way to deal with depression and anxiety in the sense of struggle which—as phenomenon—may be called ‘‘negative,’’ while in reality, it is a positive part of vital religiosity/spirituality (Pargament et al. 2011; King et al. 2017).

Another relevant result was that most of the aging German Roman Catholic priests who participated in this research showed higher Task-Oriented Coping than Avoidance-

Oriented Coping and Emotion-Oriented Coping, and positive RC than negative RC. This suggests that many priests cope with stress, challenges, or threats mainly in an adaptive form fostering personal developments (Ouwehand et al. 2007). Usually, studies found that individuals report higher means of adaptive than maladaptive coping (Penley et al. 2002; Páez and Costa 2014). Task coping positively correlates with mental health outcomes (main weighted r = .19). On the contrary, Emotional Coping (venting, confrontation, and rumination) correlates negatively (r = -.26) (Páez and Costa 2014). We also found that Emotion-Oriented Coping and Negative RC correlate strongly with psychosomatic symptoms while CISS Task and positive RC do not correlate.

Previous studies found that task coping correlates weakly r = -.23 with symptoms and Emotional Coping correlates weakly between r = .18 to r = .30 (Páez and Costa 2014). Their effect sizes explain between 2 and 9% of the variance, similar in size to those found by Nolen-Hoeksema and Aldao (2011). However, our effects sizes for Emotional Coping are higher explaining usually more than 20% of variance—using bivariate correlations as reference. We wonder whether this could be a special result of this sample in contrast to other populations.

Both Task-Oriented Coping and Priests' role identification are correlating with lower symptoms scores. Identification with the role of priest seems to be a protective factor against psychosomatic symptoms, especially in the case of depression—or depression may result in lower role identification. Social identification with the organizational role is a socio-cognitive variable that helps to a coherent self-definition and is related to solidarity and satisfaction with the group. A lot of studies showed that social identification is related to mental and physical health. For instance, a recent meta-analysis on the relationship between individuals' social identifications and health in organizations found a meanweighted r = .21 (Steffens et al. 2016). Correspondingly, priests' role identification correlates negatively with depression and to a lower extent with anxiety and somatization in this study. Moreover, identification was also associated with a more adaptive coping style, a fact that partially explains their positive association with well-being.

Multiple regressions show (Table 4) that somatization is unrelated, anxiety moderately, and depression strongly related to lower identification. Why somatization is not predicted, anxiety moderately, and depression strongly predicted by lower identification with the role? It is important to remind that some authors like Watson write that depression is a

mixture of high negative affect and low positive affect, which is more sensitive to social integration. Anxiety implies mainly high negative affect (Watson et al. 1999). Negative affect appears to be related to neuroticism, self-reported stress, health complaints, somatization, and the frequency of unpleasant events. Positive affect has been found to correlate with extraversion, sociability, and the frequency of pleasant events (Maybery et al. 2006). Probably, social identification reflects more positive attitudes toward the social milieu, a more pleasant and frequent social contact, and by the path of increased positive affect decreases depressive symptoms, with low influence on anxiety and weaker on somatic reactions—both strongly related to stress. It is also important to remind that somatization was predicted only by Emotional Coping and shows the lowest explained variance. Probably, somatization is related not only to stress and how priest cope with, but also reflects body reactions linked to illness problems.

Younger senior priests' group reported more Task- and Emotion-Oriented Coping. Our results do not confirm the results of Nolen-Hoeksema and Aldao (2011). Researchers propose that the use of most emotion regulation strategies (rumination, suppression, reappraisal, problem-solving, acceptance, social support) declines with age, with two exceptions: (1) use of suppression increased with age for women but not for men and (2) use of acceptance did not decrease with age for women. In our sample of older priests, we studied only men, but their emotion regulation strategies did not decline with age. Our study includes BSI_symptoms such as depression, anxiety, and somatization, which are similar or higher in comparison among younger and senior priests.

We agree with Charles and Carstensen (2008), who state that the Task-Oriented scale contains items of psychopathologic symptoms, such as extreme reactions of anxiety with pathological nuances. It should explain moderate correlations in our study. Moreover, there are no differences in depression between relatively younger and older priest—congruent with the fact that young priests report both higher positive and negative forms of coping. Almost two-thirds of the subjects younger than 75 years were still working, most of them as leading parish priests, and some of the older priests were active in diocesan work. The results have shown that priests from the younger group (65–75) present higher levels of Task-Oriented Coping than the older group (75–85). These outcomes confirm similar results of recent research about priests' perceptions of success and failure in their lives. Some studies indicate that Roman Catholic priests are satisfied with their ministry

(Frick et al. 2016; Kane and Jacobs 2015b). Nevertheless, there is a concern about how and when retirement would be a good option (Kane and Jacobs 2015a).

Implications for Practice

We found in our research that Task-Oriented Coping, Role Identification, and low negative RC are protective factors for priests' psychological well-being. Previous data also show that Task-Oriented Coping strengthens autonomy, personal growth, and purpose in life (Ryff et al. 2004; Stewart-Sicking 2012). It is important that priests be aware of this finding. If we realize that in the next 10 years, this cohort ''A'' of senior priests will grow older and must become cohort ''B,'' it would be recommended for cohort ''A'' to begin to prepare themselves—and also younger priests—in order to deal with a high risk factor like negative Emotion-Oriented Coping (e.g., rumination, disengagement, blame).

New skills, knowledge, expertise, and acceptance may also help older priests to solve daily-life problems and regulate their emotions (Blanchard-Fields 2007). Some studies suggest that spiritual activities such as prayer maintain and improve well-being (Piedmont 2009). However, these conclusions should be qualified because positive RC did not play a role in attenuating symptoms in this study and it did not correlate with psychosomatic symptoms. Moreover, our recent study found that transcendent spirituality had only a weakly positive influence on stress-related impairment of health (Frick et al. 2016). Probably, maintaining role identification and direct or task coping, as well as helping to decrease negative RC, could be more helpful.

Limitations

An important limitation of this study was the cross-sectional design, which does not allow for causal interpretations; longitudinal studies would be needed to substantiate the findings of this study. Secondly, due to the difficulties older priests had with fully completing the questionnaires, the sample was reduced to 499 subjects and it was not possible to use other scales. Thirdly, this study lacked a comparison with other professional groups. The fact that we measured only ill-being or symptoms and not positive psychological well-being is another important limitation. Another limitation is that many priests are not retired yet in the group of [65 and \75. Even those who are officially retired remain active on a voluntary and part-time basis. Finally, it would be ideal, in order to adequately assess the

religious and spiritual experiences of older priests, to supplement this study with qualitative research. Such a study with semi-structured interviews is presently in progress.

Compliance with Ethical Standards

Conflict of interest: All the authors declare that they have no conflict of interest.

Human and Animal Rights: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed Consent It was obtained from all individual participants included in the study.

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