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**THE RELATIONSHIPS BETWEEN POOR HEALTH, COPING STYLES,
AND HEALTH PRACTICES: A TEST OF SEVERAL POSSIBLE
MODERATORS**

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THE RELATIONSHIPS BETWEEN POOR HEALTH, COPING STYLES, AND
HEALTH PRACTICES: A TEST OF SEVERAL POSSIBLE MODERATORS

A thesis submitted in partial fulfillment
of the requirements for the degree of

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at

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ABSTRACT

THE RELATIONSHIPS BETWEEN POOR HEALTH, COPING STYLES, AND HEALTH PRACTICES: A TEST OF SEVERAL POSSIBLE MODERATORS

Pawel Sadowski

This study sought to examine the relationship between poor health and coping styles and the relationship between poor health and health practices. Another goal of this study was to observe if variables such as depression, religiosity, and locus of control might serve as moderators of these relationships. The participants and data used in this study were from the Eugene-Springfield Community Sample. The materials used included the Health Practices Questionnaire (HPQ), the Personal Attribute Survey (PAS), the Comprehensive Health Survey (CHS), and the Experimental Personality Survey (EPS). Structural equation modeling was used to analyze the data. The results revealed that poor health was positively associated with distraction coping, instrumental coping, emotional-preoccupation coping, and health practices. Furthermore, depression was positively associated with emotional-preoccupation coping; religiosity was positively associated with distraction coping, palliative coping, and instrumental coping as well as health practices; and locus of control was negatively associated with emotional-preoccupation coping. No moderating effect of depression, religiosity, or locus of control was found on the relationships between poor health, coping styles, and health practices.

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INTRODUCTION

Based off data drawn from the 2018 National Health Interview Survey, Boersma et al. (2018) estimated that 51.8% of adults in the U.S. had a chronic condition including, but not limited to, cancer, hypertension, or stroke. Additionally, it was estimated that 27.2% of adults in the U.S. had several chronic conditions (Boersma et al., 2018). These estimates indicate that there is a high prevalence of chronic conditions and a moderate prevalence of multiple chronic conditions among U.S. adults. It is possible that having a chronic condition influences how an individual copes with that condition and the health practices they engage in. In turn, the coping styles and health practices can potentially reduce or eliminate the negative effects of that condition.

Health Coping

Previous research has demonstrated that coping styles play an important role in influencing health outcomes (Olf et al., 1993; Park & Adler, 2003). Endler et al. (1998) define coping as behavioral and cognitive attempts to adjust external or internal factors. In their research, Olf et al. (1993) observed that “instrumental mastery-oriented coping” moderated the relationship between stressful situations and subjective measures of health. Their results illustrated that individuals who scored high on instrumental coping were less likely to report health complaints when encountering stressful experiences compared to individuals who scored low on instrumental coping. Another study carried out by Park and Adler (2003) revealed that first year medical students who engaged in problem-focused coping and emotion-focused coping experienced fewer negative changes in their health. These findings illustrate a clear relationship between coping and health. In a literature review written by Endler et al. (1993), the authors mention that the literature on

coping fails to observe issues with coping among individuals who are medically ill. This also seems to be the case today as much of the literature does not examine the relationship between chronic poor health and health coping styles among adults. As a result, it would be beneficial for research to examine how individuals with chronic health conditions cope with these conditions.

Health Practices

Researchers have found that health practices can also have an influence on health outcomes (Cwikel et al., 1988; Cooper et al., 2020). Cwikel et al. (1988) discovered that better health practices, including activities such as sleeping for 7-8 hours each night and regular exercise, were predictive of less chronic health conditions and more positive health ratings. On the other hand, poor health practices, which included activities such as smoking cigarettes and excessive alcohol use, were found to contribute to chronic illness (Cwikel et al., 1988). Similarly, research carried out by Cooper et al. (2020) revealed an association between higher engagement in healthy behaviors and lower risk for unfavorable health outcomes. Previous research has also demonstrated that individuals with lower levels of knowledge regarding health behaviors had a greater likelihood of reporting that they have at least one chronic illness (Stanton et al., 2016). This demonstrates the importance of health practices in influencing health outcomes.

Causal Direction

Historically, coping, good health practices and depression have been viewed as “causes” of health and our initial conceptual model was based on this view. Specifically, this study sought to explain how depression might influence health outcomes, coping styles, and health practices as well as how religiosity might serve as a moderator in the

relationships between these variables. It was expected that depression would have a direct and indirect effect on health outcomes by influencing coping styles and health practices. Additionally, it was expected that coping would have a direct and indirect effect on health outcomes by influencing health practices. However, this conceptualization was not supported by our initial analyses where, contrary to the general view that coping and good health practices lead to fewer health problems, we found that coping and better health practices were *positively* related to chronic health problems and depression was negatively associated with health problems. That is, at least for chronic health problems, it appears the causal direction is reversed. Thus, having a chronic condition may lead people to engage in more coping and better health practices, and these may be moderated by depression, religiosity, and locus of control.

Potential Moderators of the Relationships Between Poor Health, Coping Styles, and Health Practices

A study by Wink et al. (2005) observed that religiousness served as a buffer against depression for individuals who suffered from poor physical health in late adulthood. Their results demonstrated that participants with low levels of religiousness and poor physical health had the highest levels of depression. Furthermore, Wink et al. (2005) discovered that the moderating effect of religiousness occurred even when social support was controlled for. Additionally, they found that spirituality, which was operationalized as devotion to religious practices and beliefs that were noninstitutionalized, did not have a moderating effect on the relationship between depression and health. These findings inspired the present study to examine if variables

such as depression, religiosity, and locus of control can have a moderating effect on the relationships between poor health, coping styles, and health practices.

Depression

According to the Global Burden of Diseases, Injuries, and Risk Factors Study 2017, over 264 million people struggle with depression (GBD Disease and Injury Incidence and Prevalence Collaborators, 2018). Additionally, previous research has discovered a negative relationship between self-ratings of health and depression (Gellis & Taguchi, 2004; Hossain et al., 2020). Depression, along with anxiety, have also been found to be strong predictors of poorer physical health (Niles & O'Donovan, 2019). Researchers have also observed that depression can be a prodrome of medical disorders including lung cancer, pancreatic cancer, and myocardial infarction (Cosci et al., 2015). Moreover, Rieckmann et al. (2006) found that severity of depression was associated with medication nonadherence. Although much of the literature demonstrates that depression has a negative effect on health and health practices, it does not describe how depression might moderate the relationships between health, coping styles, and health practices.

Religiosity

There are some mixed findings when examining the relationships between religiosity, health, and health practices. In their study, Clark et al. (2018) discovered that religious beliefs and behaviors were associated with increases in active spiritual health locus of control. A higher active spiritual health locus of control signified that participants were more likely to feel a sense of responsibility for their health and work to achieve good health outcomes. Rodríguez-Galán and Falcón (2018) observed that religion served as a coping resource for the participants in their study and helped them to

deal with issues such as depression and high blood pressure. Additionally, they found that religion positively influenced well-being and promoted healthy behaviors among their participants (Rodríguez-Galán & Falcón, 2018). However, a study done by Speed (2018) revealed that higher levels of church attendance were associated with poorer screening behaviors in general. Moreover, the previously mentioned study done by Clark et al. (2018) also found that religious behaviors were associated with higher levels of passive spiritual health locus of control on some health outcomes. A passive spiritual health locus of control was defined as not taking responsibility for one's health and not engaging in healthy behaviors as a result. Overall, these findings demonstrate that religiosity can either enhance or reduce engagement in health practices which in turn can influence health outcomes. However, the potential moderating effects of religiosity are not examined.

Locus of Control

Willis et al. (1997) observed that there was no significant relationship between health locus of control and health outcomes. Additionally, a longitudinal study by Wallhagen et al. (1994) found no relationship between internal health locus of control, which was defined by the belief that an individual is in control of what happens to them, and health behaviors. The only health behavior that internal health locus of control was associated with was a change in eating patterns during illness. However, internal health locus of control was associated with the belief that good health was important (Wallhagen et al., 1994). Other research has demonstrated that internal locus of control was associated with lower levels of self-reported poor health and psychological distress (Gale et al., 2008). Therefore, locus of control is another factor that may or may not

influence health outcomes and health practices. Moreover, locus of control could be a factor that might moderate the relationships between poor health, coping, and health practices.

Present Study

The present study seeks to examine the relationship between poor health and health coping styles and the relationship between poor health and engagement in health practices. Poor health was defined as having one or more of the following conditions: heart disease, stroke, high blood pressure, high cholesterol, diabetes, and cancer. The health coping styles included distraction coping, instrumental coping, palliative coping, and emotional-preoccupation coping. Health practices include activities such as eating a balanced diet, getting enough sleep, and exercising. This study also seeks to observe if factors such as depression, religiosity, and locus of control can serve as moderators in the relationships between poor health, coping styles, and health practices.

Hypotheses

The first hypothesis is that poor health will be associated with more engagement in the various coping styles and health practices. The second hypothesis is that depression will be associated with distraction and emotional preoccupation coping while moderating the relationship between poor health and coping styles and the relationship between poor health and health practices. The third hypothesis is that religiosity will be associated with instrumental and palliative coping while moderating the relationship between poor health and coping styles and the relationship between poor health and health practices. Additionally, we wanted to explore if another variable, locus of control, would have any moderating effects on the relationships between poor health, coping styles, and health

practices. Therefore, the fourth hypothesis is that locus of control will serve as a moderator in the relationship between poor health and coping styles and the relationship between poor health and health practices.

Method

Participants

The data used in this study were collected by Lewis R. Goldberg at the Oregon Research Institute. The participants included individuals ($n = 900$) from the Eugene-Springfield Community Sample that were recruited in 1993 using lists of homeowners. During the initial recruitment stage, the age of participants ranged from 18 to 85 (Goldberg, 2008).

Measures

The questionnaires that were used in this study include the Health Practices Questionnaire (HPQ), the Personal Attribute Survey (PAS), the Comprehensive Health Survey (CHS), and the Experimental Personality Survey (EPS). The HPQ measured three factors including health concerns, risk-avoidance, and good health practices. The data from this questionnaire were used for the health practices variable. The PAS measured factors such as locus of control, optimism, and self-esteem among many other personality factors. The data from this survey that measured locus of control were used for the locus of control variable. The measure for locus of control was developed by Levenson (1981). The CHS observed health-related coping styles, tobacco and alcohol consumption, and other factors concerning physical and mental health. The measure for health-related coping styles was formulated by Endler et al. (1998). The data from this survey that measured chronic health problems and coping styles were used in the data analysis. The EPS assessed levels of depression, spirituality, and various personality traits. The measure for depression was the revised CES- Depression Scale developed by Radloff (1977) and the measure for spirituality was the revised Expressions of Spirituality

Inventory formulated by MacDonald (2001). The data from this survey that measured depression and the items on the spirituality inventory that measured religiosity were used to observe levels of depression and religiosity.

The raw data and calculated scores from the questionnaires and surveys mentioned above were drawn from the Harvard Dataverse website (Goldberg & Saucier, 2018) and placed into SPSS 27 for initial observation and analysis. In SPSS, the data regarding chronic health conditions were used to create a dichotomous variable indicating whether an individual had or did not have a chronic condition. Furthermore, the items that measure depressive symptoms were added together to create a variable for depression while the items in the spirituality measure that observed religiosity were summed to create a variable measuring religiosity. The other variables including coping styles, health practices, and locus of control had scores that were already calculated on the Harvard Dataverse website. These scores were used in the data analysis.

Statistical Analyses

Descriptive statistics and simple correlations were computed among the observed variables. The primary analysis was Structural Equation Modeling using both latent and observed variables. Continuous independent variables were mean-centered before the analyses. Overall model fit was evaluated using the Comparative Fit Index (CFI) and a model was viewed as providing acceptable fit if the CFI was greater than .90. Standardized path coefficients are reported. Maximum Likelihood estimation was used and participants with missing data were excluded from the models.

Results

Poor Health, Coping Styles, Health Practices, and Depression

The descriptive statistics for the variables used in this study are displayed in Table 1 while the simple correlations between the variables are displayed in Table 2. The SEM analysis that included poor health, coping styles, health practices, and depression ($n = 656$) revealed a CFI value of 0.915. Additionally, the SEM analysis indicated that poor health was significantly associated with distraction, instrumental, and emotional-preoccupation coping as well as health practices. The analysis also revealed that depression was associated with emotional-preoccupation coping. The standardized path coefficients are as follows: poor health and distraction coping 0.184 ($p < 0.001$), poor health and instrumental coping 0.161 ($p < 0.001$), poor health and emotional-preoccupation coping 0.085 ($p = 0.024$), poor health and health practices 0.187 ($p < 0.001$), and depression and emotional-preoccupation coping 0.264 ($p < 0.001$). No moderating effect of depression on the relationships between poor health, coping styles, and health practices was observed (see Figure 1 and Table 3).

Poor Health, Coping Styles, Health Practices, and Religiosity

The SEM analysis that involved poor health, coping styles, health practices, and religiosity ($n = 672$) demonstrated a CFI value of 0.946. This analysis also displayed an association between poor health and every coping style except palliative coping, as well as an association between poor health and health practices. Furthermore, the results of this analysis revealed an association between religiosity and every coping style except emotional-preoccupation coping and an association between religiosity and health practices. The standardized path coefficients included: poor health and distraction coping

0.152 ($p < 0.001$), poor health and instrumental coping 0.133 ($p < 0.001$), poor health and emotional-preoccupation coping 0.086 ($p = 0.029$), poor health and health practices 0.178 ($p < 0.001$), religiosity and distraction coping 0.149 ($p = 0.003$), religiosity and palliative coping 0.151 ($p = 0.011$), religiosity and instrumental coping 0.149 ($p = 0.007$), and religiosity and health practices 0.320 ($p < 0.001$). There was no moderating effect of religiosity on the relationships between poor health, coping styles, and health practices (see Figure 2 and Table 4).

Poor Health, Coping Styles, Health Practices, and Locus of Control

The SEM analysis with poor health, coping styles, health practices, and locus of control ($n = 684$) indicated a CFI value of 0.945. This analysis showed similar associations between poor health, coping styles, and health practices. Moreover, this analysis revealed a negative association between locus of control and emotional-preoccupation coping. The standardized path coefficients included: poor health and distraction coping 0.173 ($p < 0.001$), poor health and instrumental coping 0.136 ($p < 0.001$), poor health and emotional-preoccupation coping 0.103 ($p = 0.008$), poor health and health practices 0.199 ($p < 0.001$), and locus of control and emotional-preoccupation coping -0.156 ($p = 0.004$). This analysis also demonstrated no moderating effect of locus of control on the relationships between poor health, coping styles, and health practices (see Figure 3 and Table 5).

Discussion

The results of the SEM analyses demonstrated that having a chronic condition had a small, positive association with engagement in distraction, instrumental, emotional-preoccupation coping, and health practices. This partially confirms the first hypothesis in the part that postulates that poor health would be associated with more engagement in coping and health practices. The analyses also revealed a small, positive association between depression and emotional-preoccupation coping, although no moderating effect of depression on the relationships between poor health, coping styles, and health practices was found. These findings confirm the portion of the second hypothesis that stated that depression would be associated with emotional-preoccupation coping. Furthermore, the analyses exhibited small, positive associations between religiosity and distraction, palliative, and instrumental coping as well as a medium, positive association between religiosity and health practices. There was also no moderating effect of religiosity on the relationships between poor health, coping styles, and health practices. These results partially confirm the third hypothesis since religiosity was associated with instrumental and palliative coping. The last analysis revealed a small, negative association between locus of control and emotional-preoccupation coping. However, there was no moderating effect of locus of control on the relationships between poor health, coping, and health practices which left the fourth hypothesis unconfirmed.

The findings of the current study build on the findings of Olf et al. (1993) which found a relationship between instrumental coping and subjective health measures. The current study demonstrates that instrumental coping is also associated with poor health. However, this study does not examine how coping might influence improvement in

health conditions which could be measured by subjective health measures such as those used by Olf et al. (1993). Cwikel et al. (1988) demonstrated that good health practices predicted less health conditions while the current study illustrates that poor health is also associated with health practices. Future research can examine how good health practices among individuals with health conditions might change over time and how these changes in turn might affect their health condition. Furthermore, Gale et al. (2008) observed a negative association between internal locus of control and self-reported poor health. Since this study used locus of control in general, future studies can attempt to examine if internal locus of control might moderate the relationships between poor health, coping styles, and health practices. A limitation of this study includes the fact that different surveys were administered at different points in time which could have influenced the results. For example, the CHS which measured health conditions and coping styles was administered during the spring of 1999 while the EPS which measured depression and religiosity was administered during the summer of 2002. Therefore, future studies can administer these surveys all at once and examine if the same relationships are found.

Table 1*Descriptive Statistics*

Variable	<i>n</i>	<i>M</i>	<i>SD</i>
1. Health ^a	760	0.50	0.50
2. Depression	726	41.21	13.57
3. Religiosity	726	20.24	7.42
4. Total Locus of Control	725	3.89	0.42
5. Distraction Coping	748	2.61	0.80
6. Palliative Coping	748	2.71	0.80
7. Instrumental Coping	749	3.73	0.84
8. Emotional-Preoccupation Coping	748	2.51	0.87
9. Risk Avoidance	706	3.77	0.61
10. Health Concerns	706	3.39	0.54
11. Health Practices	706	3.81	0.57

^a 0 = no chronic conditions and 1 = one or more chronic conditions reported

Table 2*Simple Correlations*

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Health	—										
2. Depression	-.01	—									
3. Religiosity	.11**	-.04	—								
4. Total Locus of Control	-.003	-.25**	-.05	—							
5. Distraction Coping	.18**	-.03	.21**	.04	—						
6. Palliative Coping	-.01	.09*	.15**	-.01	.27**	—					
7. Instrumental Coping	.14**	-.01	.16**	.09*	.44**	.29**	—				
8. Emotional-Preoccupation Coping	.09*	.26**	.05	-.14**	.27**	.26**	.26**	—			
9. Risk Avoidance	.17**	-.003	.33**	-.06	.13**	.17**	.23**	.08	—		
10. Health Concerns	.14**	-.04	.24**	-.08	.19**	.22**	.31**	.09*	.45**	—	
11. Health Practices	.02	-.30**	.11**	.16**	.13**	.10*	.17**	-.12**	.26**	.40**	—

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

Table 3*Moderator Analysis: Poor Health, Coping Styles, Health Practices, and Depression*

	Standardized Path Coefficient	SE	95% CI		p
			LL	UL	
Health Practices and Health	.187	.052	.102	.275	<.001
Health Practices and Depression	-.089	.082	-.226	.049	.281
Health Practices, Health, and Depression	-.013	.077	-.146	.110	.866
Distraction Coping and Health	.184	.038	.122	.247	<.001
Distraction Coping and Depression	.006	.052	-.079	.092	.912
Distraction Coping, Health, and Depression	-.034	.053	-.121	.053	.519
Palliative Coping and Health	-.002	.039	-.066	.064	.951
Palliative Coping and Depression	.127	.065	.020	.233	.050
Palliative Coping, Health, and Depression	-.039	.057	-.135	.053	.491
Instrumental Coping and Health	.161	.038	.098	.223	<.001
Instrumental Coping and Depression	.042	.056	-.052	.134	.451
Instrumental Coping, Health, and Depression	-.089	.055	-.183	-.002	.107
Emotional-Preoccupation Coping and Health	.085	.038	.023	.148	.024
Emotional-Preoccupation Coping and Depression	.264	.055	.177	.357	<.001
Emotional-Preoccupation Coping, Health, and Depression	.009	.056	-.086	.100	.877

Note. $n = 656$. SE = standard error. CI = confidence interval; LL = lower limit; UL = upper limit.

Table 4*Moderator Analysis: Poor Health, Coping Styles, Health Practices, and Religiosity*

	Standardized Path Coefficient	SE	95% CI		p
			LL	UL	
Health Practices and Health	.178	.050	.098	.263	<.001
Health Practices and Religiosity	.320	.075	.191	.437	<.001
Health Practices, Health, and Religiosity	.071	.068	-.042	.184	.303
Distraction Coping and Health	.152	.038	.090	.214	<.001
Distraction Coping and Religiosity	.149	.050	.067	.232	.003
Distraction Coping, Health, and Religiosity	.059	.050	-.022	.141	.238
Palliative Coping and Health	-.035	.038	-.098	.029	.367
Palliative Coping and Religiosity	.151	.059	.051	.246	.011
Palliative Coping, Health, and Religiosity	-.002	.053	-.087	.088	.973
Instrumental Coping and Health	.133	.038	.069	.196	<.001
Instrumental Coping and Religiosity	.149	.055	.054	.238	.007
Instrumental Coping, Health, and Religiosity	.005	.053	-.079	.095	.922
Emotional-Preoccupation Coping and Health	.086	.039	.021	.150	.029
Emotional-Preoccupation Coping and Religiosity	.038	.053	-.048	.124	.467
Emotional-Preoccupation Coping, Health, and Religiosity	-.003	.053	-.091	.084	.955

Note. $n = 672$. *SE* = standard error. *CI* = confidence interval; *LL* = lower limit; *UL* = upper limit.

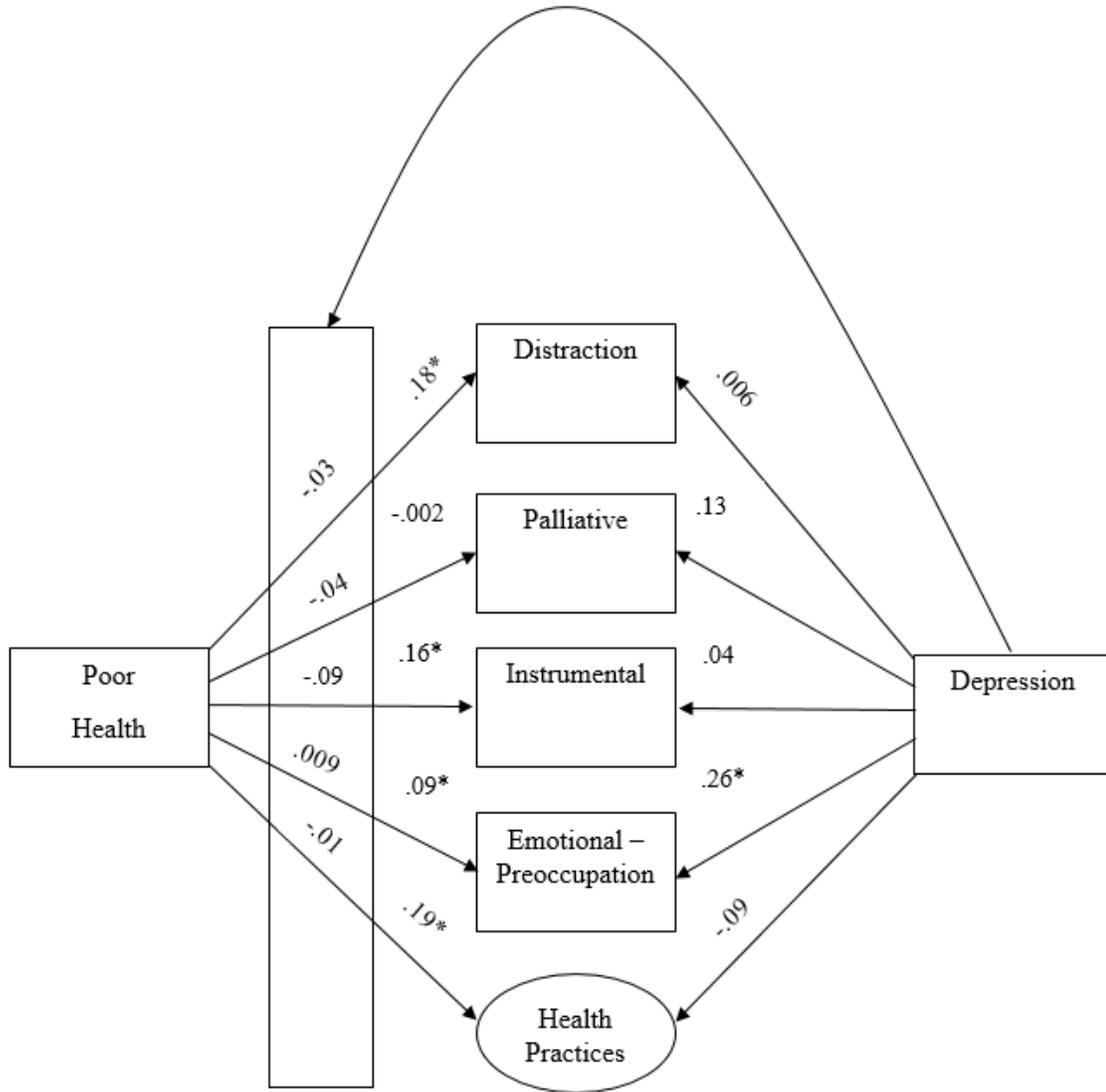
Table 5*Moderator Analysis: Poor Health, Coping Styles, Health Practices, and Locus of Control*

	Standardized Path Coefficient	SE	95% CI		p
			LL	UL	
Health Practices and Health	.199	.050	.119	.280	<.001
Health Practices and Locus of Control	-.093	.072	-.213	.025	.195
Health Practices, Health, and Locus of Control	.038	.069	-.077	.153	.583
Distraction Coping and Health	.173	.038	.109	.235	<.001
Distraction Coping and Locus of Control	-.007	.057	-.102	.085	.907
Distraction Coping, Health, and Locus of Control	.060	.055	-.028	.152	.275
Palliative Coping and Health	-.014	.039	-.078	.049	.717
Palliative Coping and Locus of Control	-.041	.069	-.158	.069	.558
Palliative Coping, Health, and Locus of Control	.038	.063	-.061	.146	.543
Instrumental Coping and Health	.136	.037	.075	.197	<.001
Instrumental Coping and Locus of Control	.061	.061	-.039	.162	.318
Instrumental Coping, Health, and Locus of Control	.035	.059	-.061	.133	.559
Emotional-Preoccupation Coping and Health	.103	.038	.038	.165	.008
Emotional-Preoccupation Coping and Locus of Control	-.156	.054	-.244	-.068	.004
Emotional-Preoccupation Coping, Health, and Locus of Control	.028	.056	-.060	.125	.621

Note. $n = 684$. *SE* = standard error. *CI* = confidence interval; *LL* = lower limit; *UL* = upper limit.

Figure 1

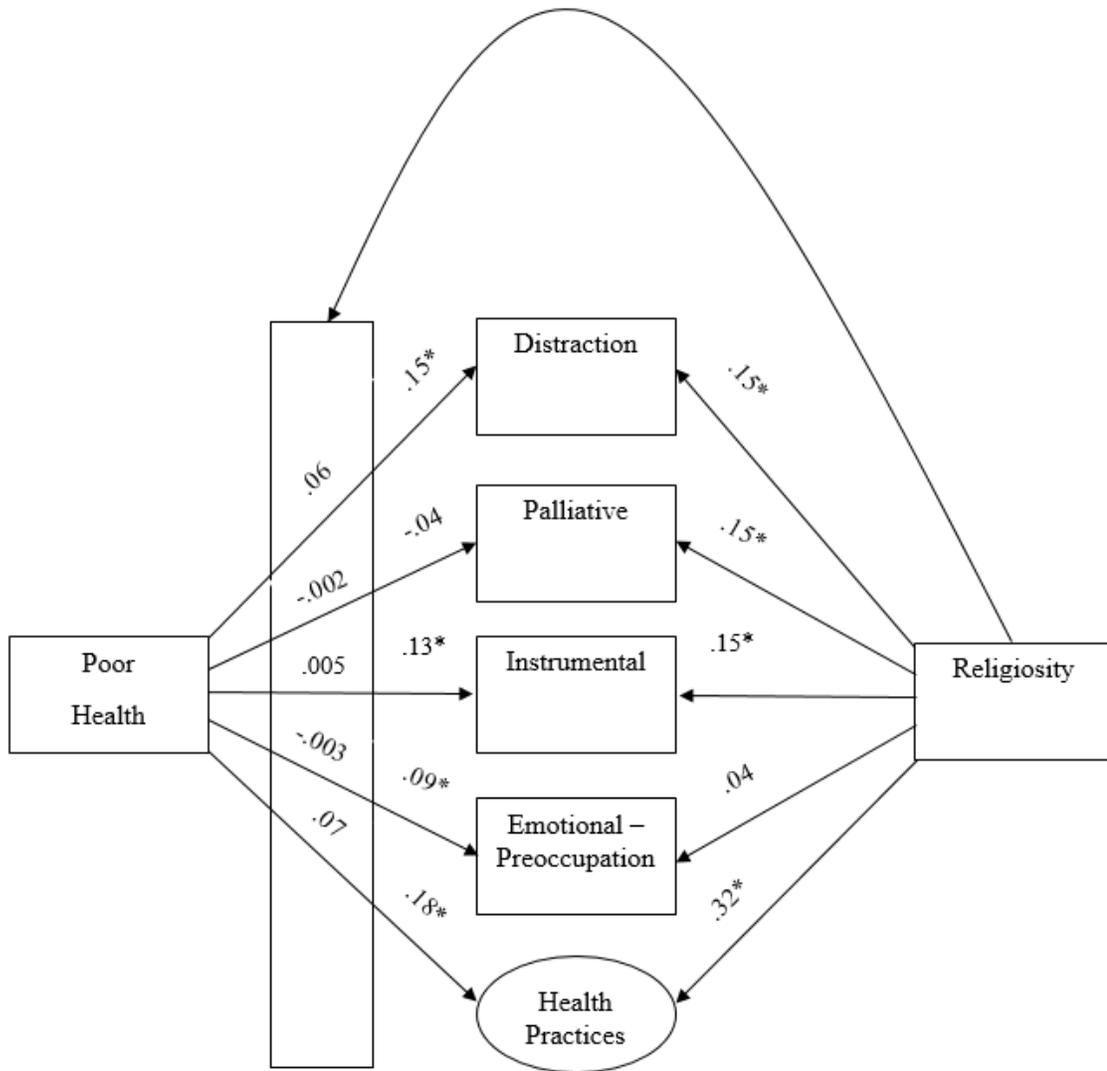
Associations between Poor Health, Coping Styles, Health Practices, and Depression



* $p < .05$

Figure 2

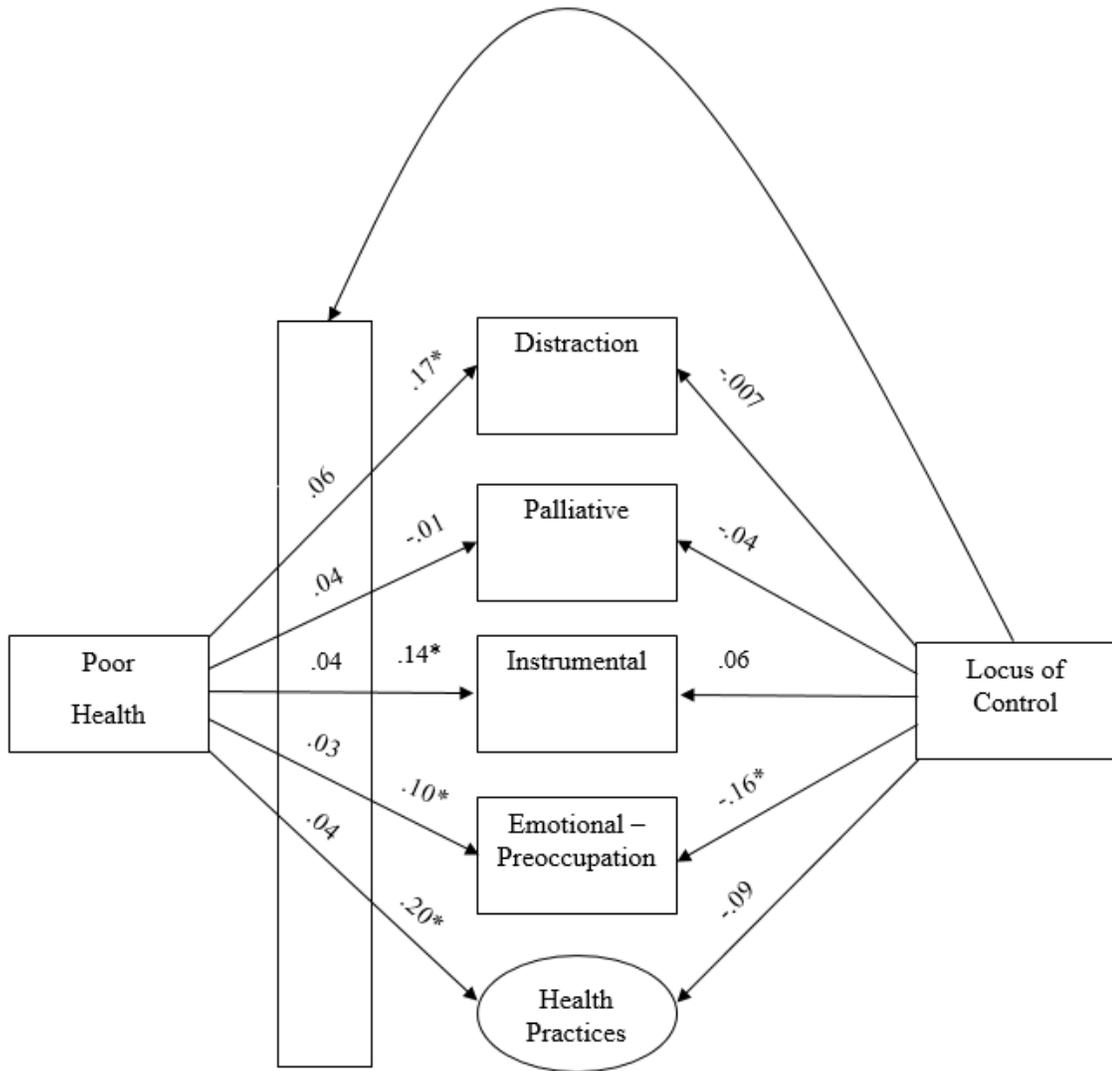
Associations between Poor Health, Coping Styles, Health Practices, and Religiosity



* $p < .05$

Figure 3

Associations between Poor Health, Coping Styles, Health Practices, and Locus of Control



* $p < .05$

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