Religiousness and Spirituality in Coping with Cancer

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Definitions of Religiousness and Spirituality

There has been much debate in the literature over exactly how religiousness and spirituality should be defined. Religion is often described as institutional and formal, while spirituality is seen as more informal, existential, and personal [1]. This may not always be the case however. Indeed, religion is a multidimensional construct that may involve spiritual experiences, meaning, values, beliefs, forgiveness, private and public religious practices, religious coping, religious support, commitments and preferences [2]. Spirituality may also be viewed as a multidimensional construct that can be divided into three main dimensions: (1) a God-orientated spirituality where thoughts and practices are premised in theologies; (2) a world-orientated spirituality stressing relationships with ecology or nature, and (3) a humanistic spirituality (or people orientated) stressing human achievement or potential [3].

The use of the term "spirituality" as being apart from religion has a surprisingly short history [4, 5] and evolved mainly from a growing disillusionment with religious institutions in Western society during the 1960s and 1970s. Today, it is often associated with more favorable connotations to religion [6] and appears to be the terminology favored by healthcare professionals, especially within oncology and palliative care. However, viewing religiousness and spirituality as distinct and separate constructs may potentially ignore the rich and dynamic interaction between the two [7]. Studies have generally found defining religiousness and spirituality problematic, and empirical studies examining people's understanding of these concepts have produced conflicting results to the notion of separate constructs. For example, Zinnbauer et al. [8] found that religiousness and spirituality were not totally independent and that as many as 74% considered themselves both religious and spiritual. A large overlap between the two concepts, with many similarities in terms of beliefs, time spent in prayer, guidance, a sense of right and wrong, and a connection to God, also exists [9]. Indeed, Scott [10] found that definitions of religiousness and spirituality were evenly distributed across nine content categories: (1) experiences of connectedness or relationships; (2) processes leading to increased connectedness; (3) behavioral responses to something sacred; (4) systems of thoughts or set beliefs; (5) traditional institutional or organizational structures; (6) pleasurable states of being; (7) beliefs in the sacred or transcendent; (8) attempts at or capacities for transcendence; and (9) concerns for existential questions or issues. This further

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demonstrates a substantial diversity in the content of people's understanding of religiousness and spirituality and signifies a considerable overlap between the two constructs. Both may involve a search for meaning and purpose, transcendence, connectedness, and values. Religious involvement can therefore be similar to spirituality. Equally, spirituality may also have communal or group expressions. When these expressions are formalized, spirituality is more like an organized religion [11].

Most studies examining definitional issues surrounding religiousness and spirituality have been conducted in the USA. Therefore, before commencing research in this area at UCL in London, UK, my colleagues and I conducted a brief assessment into the definitional views of religiousness and spirituality in a London population to gain a clearer idea of how people in the UK view these concepts [12]. Although we are not in a position to generalize these findings to the UK population as a whole, in line with previous US findings, results from these interviews show that people in the UK may also have different, and often overlapping, understandings of religiousness and spirituality, although most did not view these terms in any great detail. Being religious was understood in three different ways: having a belief in God or devotion to one's faith (non-organizational), belonging to an organized religion (attending church and adhering to the doctrine of a particular religion) or it may also incorporate both of these. Equally, spirituality was viewed in different ways, as being separate from religion, where it was seen as a broader non-organizational concept with a strong dedication to one's faith. Some viewed it as providing meaning to a person's life and as being similar to religion, describing spiritual people as practicing in much the same way as a religious person might. Others found spirituality difficult to define with some tending toward a "New Age" or Eastern philosophy rather than associating it with more organized religions. Finally, some felt that spirituality was something they associated with people being "a bit phoney."

The variations in people's ideas about these concepts show that it may be more useful to concentrate on the content behind their understanding of religiousness and spirituality rather than focusing on the label itself. Indeed, within medically ill populations, how patients use their spirituality or religiousness in the coping process has been a growing area of interest to healthcare researchers.

Religious/Spiritual Coping

Since 1985, 30% of coping studies in the literature have examined some aspect of coping with cancer [13]; yet despite significant interest in the coping process being evident in the last 30 years, the role of religion and spirituality in coping with illness has received relatively little attention as an area of study in its own right. For example, up until 1998, only 1% of coping studies had examined the use of faith in coping [14]. This is surprising, especially as its role in the appraisal process may lead to both cognitive (e.g., appraising an illness as part of God's plan) and behavioral (e.g., praying or attending religious services) aspects of coping. Religious/spiritual coping can therefore be defined as "The use of cognitive and behavioral techniques, in the face of stressful life events, that arise out of one's religion or spirituality" [14]. The term "religious coping" will be used throughout this chapter simply because it is the term generally used in the literature. However, it does, of course, incorporate the coping of people who view themselves as spiritual and not religious. Other terms such as "spiritual needs" will be used as it is also the term generally used in the literature. It too includes those who regard themselves as religious and therefore have religious needs.

Nature of Religious Coping

Turning to religion during times of difficulty has been described in the literature as a form of escapism, defense, denial, avoidance, passivity, or dependence [15], and the notion that religious coping is a maladaptive avoidant coping strategy was first argued by Freud [16] who believed that

people who turn to religion do so from a sense of helplessness with the aim of reducing unwanted tensions and anxieties: "Religion is a universal obsessional neurosis … infantile helplessness … a regression to primary narcissism." By 1980, attitudes had changed little; the US psychologist Albert Ellis wrote: "Religiosity is in many respects equivalent to irrational thinking and emotional disturbance … The elegant solution to emotional problems is to be quite unreligious … the less religious they are, the more emotionally healthy they will be" [17]. However, this view is simplistic and stereotypical and fails to consider the diverse roles religious/spiritual beliefs, practices, and communities play in people's attempts to find some sort of significance in their lives [15]. Although religious coping can be avoidant, passive, ineffective, and maladaptive, it may also be adaptive, active, and problem-focused in nature [18]. Public religious/spiritual practices (e.g., attending religious services at church/synagogue/mosque/temple, Sufi meetings or bible study) and private religious/spiritual practices (e.g., prayer or meditation without the influence of other like-minded people) may be conceptualized as a form of religious coping, but religious coping may also describe various religious coping cognitions. These can further be divided into positive and negative religious coping strategies. Positive religious coping is considered to be an expression of a secure relationship with a supportive God/higher power. Seeing the situation as part of God's plan and seeking God's love and care or working together with God to solve problems are examples of positive religious coping strategies. Negative religious coping (sometimes referred to in the literature as "religious struggle") is viewed as an expression of a less secure relationship with a God/higher power that is distant and punishing, or as a religious struggle in the search for significance [19]. Feeling punished or abandoned by God and reappraising God's powers or feeling let down by God are examples of negative religious coping strategies. In this chapter, the terms "negative religious coping" and "religious struggle" will be used interchangeably.

Pargament et al. [20] argue that the exploration of religious coping should be theoretically based and functionally orientated. They consider five key religious functions in coping based on various theories:

1. *Meaning*. According to theorists (e.g., Clifford Geertz, [21]), religion plays a key role in the search for meaning during suffering or during difficult life experiences. Religion offers a framework for understanding and interpretation.
2. *Control*. Theorists such as Eric Fromm [22] have stressed the role of religion in the search for control over an event that pushes an individual beyond his or her own resources.
3. *Comfort*. According to classic Freudian theory [23], religion is designed to reduce an individual's apprehensions about living in a world where disaster can strike at any moment.
4. *Intimacy*. Sociologists such as Durkheim [24] have generally emphasized the role of religion in facilitating social cohesiveness. Religion is said to be a mechanism for fostering social solidarity.
5. *Life transformation*. Religion may assist people in making major life transformations where individuals give up old objects of value to find new sources of significance [25].

Table 8.1 shows various religious coping strategies falling within Pargament et al.'s [20] five functional dimensions, and examples of each are given. Researchers should not expect to find five different factors of religious coping according to these five functions as any form of religious coping may serve more than one purpose. For example, meaning in a stressful situation can be sought in many different ways: redefining the stressor as an opportunity for spiritual growth ("benevolent religious reappraisal"), or redefining the situation as a punishment from God ("punishing God reappraisal") where the former is a potentially adaptive positive religious coping strategy, while the latter is a potentially maladaptive negative religious coping strategy. Empirical studies have indeed confirmed that different forms of religious coping have different implications for adjustment, at least in the short term [26, 27]. For example, collaborative religious coping has been associ-

Table 8.1 Examples of the functions of coping and associated religious/spiritual coping strategies along Pargament et al.'s [20] five dimensions

Religious coping strategies under the five different functions	Positive/ negative	Example of coping strategy
1. *To find meaning*		
Benevolent religious reappraisal	Positive	"Saw my situation as part of God's plan"
Punishing God reappraisal	Negative	"I wondered what I did for God to punish me"
Demonic reappraisal	Negative	"Believed the devil was responsible for my situation"
Reappraisal of God's powers	Negative	"Questioned the power of God"
2. *To gain control*		
Collaborative religious coping	Positive	"Tried to put my plan into action together with God"
Active religious surrender	Positive	"Did my best, then turned the situation over to God"
Passive religious deferral	Negative/ mixed	"Didn't do much, just expected God to solve my problems for me"
Pleading for direct intercession	Negative	"Pleaded with God to make things turn out okay", "Prayed for a miracle"
Self-directing religious coping	Mixed	"Tried to deal with my feelings without the help of God"
3. *To gain comfort*		
Seeking spiritual support	Positive	"Sought God's love and care"
Religious focus	Positive	"Prayed to get my mind off my problems"
Religious purification	Positive	"Confessed my sins"
Spiritual connection	Positive	"Looked for a stronger connection with God"
Spiritual discontent	Negative	"Wondered whether God had abandoned me"
Marking religious boundaries	Positive	"Avoided people who weren't of my faith"
4. *To gain intimacy with others/God*		
Seeking support from clergy or members	Positive	"Looked for spiritual support from religious leaders/ clergy"
Religious helping	Positive	"Prayed for the well-being of others"
Interpersonal religious discontent	Negative	"Disagreed with what the church wanted me to do or believe"
5. *To achieve a life transformation*		
Seeking religious direction	Positive	"Asked God to find a new purpose in life"
Religious conversion	Positive	"Tried to find a completely new life through religion"
Religious forgiving	Positive	"Sought help from God in letting go of my anger"

ated with better physical and mental health [18, 28, 29], while religious coping strategies such as punishing God reappraisal, demonic reappraisal, spiritual discontent, interpersonal religious discontent, and pleading for direct intercession are all associated with greater levels of distress [25]. However, there is also evidence that not all forms of religious coping fall easily into negative and positive categories but may be associated with both positive and negative outcomes. For example, self-directing (i.e., dealing with a situation without relying on God) and deferring religious coping strategies (giving over control to God) have demonstrated mixed results [19], as has pleading religious coping strategies (i.e., pleading and bargaining with God or praying for a miracle) [25].

Measurement of Religious Coping

Early studies have tended to use public religious/spiritual practices such as congregational attendance as a measure of religious coping [30, 31]. Using frequencies of religious service attendance as a coping measure is generally problematic for a number of reasons. For example, public religious/spiritual institutions/group attendance that involves meeting other like-minded people potentially expose people to social support, a variable known to predict illness adjustment which may therefore confound the results, whether the attendance is at a place of worship of an organized or non-organized religion or in someone's home (e.g., Bible study). People may also follow religious/spiritual practices for social

reasons, for example, for social approval or social status often referred to as extrinsic religiousness [32]. Measuring public religious practices may therefore not necessarily inform much about *how* people use their faith in coping and how much it is involved in, for example, their cancer diagnosis or during cancer treatment. A distinction needs to be made between habitual religious/spiritual practices and those actively involved in coping with illness. Indeed, simply enquiring about service attendance does not inform about its intended purpose. It is also important to consider that people who are ill may not be well enough to take part in public religious/spiritual practices [33]. An example of a validated public religious practice scale [34] is shown in Table 8.2.

Table 8.2 Instruments examining religious coping strategies

Authors	Measures	Description
Religious coping:		
Idler [34]	Organizational Religiousness Scale	2 items examining frequency of attendance at religious services and participation in religious/spiritual activities with other people. Cronbach's alpha = 0.82
Levin [35]	Private Religious Practices Scale	4 items examining how often people pray or meditate, read religious or spiritual literature, watch or listen to religious programs on TV or radio, and say grace before meals. Cronbach's alpha = 0.72
Lazarus and Folkman [38]	The Ways of Coping Scale	2 items, 1 item as part of the "'Escape-Avoidance" dimension; "Hoped a miracle would happen" and 1 item as part of the "positive reappraisal" dimension; "I prayed"
Carver et al. [36]	The COPE	4 items from the "'Turning to religion" sub-scale, e.g., "I try to find comfort in my religion" "I seek God's help. Cronbach's alpha = 0.92.
Carver [37]	The Brief COPE	2 items from the "'Religion" sub-scale, e.g., "I have been trying to find comfort in my religious beliefs" "I've been praying or meditating" Cronbach's alpha = 0.82
Pargament et al. [18]	The Religious Problem-Solving Scale	22 items, 3 sub-scales labeled, (1) collaborative, ("When it comes to deciding how to solve problems, God and I work together as partners" Cronbach's alpha = 0.93); (2) self-directing, ("When I have difficulty, I decide what it means by myself without relying on God" Cronbach's alpha = 0.91); (3) deferring ("Rather than trying to come up with the right solution to a problem myself, I let God decide how to deal with it" Cronbach's alpha = 0.89)
Pargament et al. [43]	The Religious Coping Activities Scale	15 items, 6 sub-scales: (1) spiritually based (e.g., "Trusted that God would not let anything terrible happen to me"); (2) good deeds (e.g., "Tried to be less sinful"); (3) discontent (e.g., "Felt angry with or distant from God"); (4) religious support (e.g., "received support from clergy"— – note, not a coping strategy but its consequence); (5) plead (e.g., "Asked for a miracle"); and (6) religious avoidance (e.g., "Focused on the world to come rather than on the problems of this world"). Cronbach's alpha = 0.61–0.92
Boudreaux et al. [42]	The Ways of Religious Coping Scale	25 items, 2 sub-scales; (1) internal/private (e.g., "I pray" "I put my problems into God's hands"); and (2) external/social (e.g., "I get support from church/mosque/temple members" "I donate time to a religious cause or activity." Cronbach's alphas = 0.93 and 0.97
Pargament et al. [20]	The RCOPE	105 items measuring positive and negative religious coping cognitions along 5 key religious functions in coping: (1) religious coping to give *meaning* to an event; (2) to provide a framework to achieve a sense of *control* over a difficult situation; (3) to provide *comfort* during times of difficulty; (4) to provide *intimacy* with other like-minded people; and (5) to assist people in making major *life transformations*. Cronbach's alpha = 0.65 or greater
Pargament et al. [19]	The Brief ROPE	14 items divided into 2 clusters of positive and negative religious coping strategies. Cronbach's alpha = 0.87 (positive sub-scale) and 0.78 (negative sub-scale)
Exline et al. [45]	The Religious and Spiritual Struggles Scale	26 items examining 6 domains of struggle: divine, demonic, interpersonal, moral, doubt, ultimate meaning. Cronbach's alpha = 0.80 to 0.96

Private religious/spiritual practices such as prayer have also been used in research to represent religion/spirituality in the coping process [30, 31]. Using this approach is limited in that it only informs about the frequency of prayer and not its content, nor does it tell us about the actual cognitions used, whether they were adaptive or maladaptive. It can, however, inform researchers about the frequency of engaging in private religious practices such as frequency of prayer and whether these change as a result of being diagnosed with cancer. As with public religious practices, attention needs to be given to whether a practice is a coping or a habitual behavior or whether it involves praying with other like-minded people whose support may contaminate the findings if not controlled for adequately in the study analyses. An example of a validated private religious practice scale [35] is shown in Table 8.2.

The importance of religious coping strategies is reflected in several commonly used coping questionnaires (e.g., the COPE by Carver et al. [36]; the Brief COPE by Carver [37]; the Ways of Coping Scale by Folkman and Lazarus [38]—Table 8.2). These questionnaire items usually involve explicit terms such as "I prayed" or "I have been trying to find comfort in my religious/spiritual beliefs." However, attempts made by "nonreligious" coping scales to classify religious coping highlight some difficulties. For example, this form of coping is often conceived as emotion focused [38], but can, as mentioned previously, also be problem focused [18]. Statements about prayer do not tell us about its content, nor does it inform about the actual coping cognitions that are used. Also, prayer is treated as a unidimensional construct when different forms of prayer may be associated with different outcomes. Some general coping measures (e.g., the Ways of Coping Scale) also ignore the possibility that religious coping might entail a unique coping dimension [37, 39–41], where religious coping items are combined within nonreligious subscales such as "positive reappraisal" and "escape-avoidance." However, the distinct nature of religious coping in comparison to other forms of coping is evident in empirical studies. For example, the religious coping items of the COPE and Brief COPE load exclusively together onto one sub-scale [36, 37]. The specific content of potentially adaptive or maladaptive coping strategies (usually cognitive in nature but also some behavioral such as seeking religious support) can be measured using the Ways of Religious Coping Scale by Boudreaux et al. [42], the Religious Problem-Solving Scale by Pargament et al. [18], the Religious Coping Activities Scale by Pargament et al. [43], and the RCOPE by Pargament et al. [20] (Table 8.2). The Ways of Religious Coping Scale includes two sub-scales: (1) internal/private (e.g., "I pray," "I put my problems into God's hands") and (2) external/social (e.g., "I get support from church/mosque/temple members," "I donate time to a religious cause or activity"). (Note that the former example is not a coping strategy, rather the possible consequence of seeking support from religious groups which, in turn, reduces the validity of this questionnaire.) Prayer is also treated as unidimensional. Although this scale has good psychometric properties (e.g., a two-factor structure and Cronbach's alpha scores of 0.93 and 0.97), it has not been extensively used.

The Religious Problem-Solving Scale [18] includes three sub-scales examining various religious coping cognitions. These are labeled as follows: (1) collaborative (where the individual and God actively work together as partners, e.g., "When it comes to deciding how to solve problems, God and I work together as partners"); (2) self-directing (where people are religious/spiritual but use coping strategies that do not involve God, e.g., "When I have difficulty, I decide what it means by myself without relying on God"); and (3) deferring (where the responsibility of coping is passively deferred to God, e.g., "Rather than trying to come up with the right solution to a problem myself, I let God decide how to deal with it"). During development, the items from the scale loaded onto three separate factors, and the sub-scales had Cronbach's alpha scores from 0.89 to 0.93. However, nonreligious people would have trouble responding to items from the "self-directing" religious coping sub-scale as this scale assesses coping strategies of religious/spiritual people who use coping strategies without

involving their faith in the coping process. The assumption is therefore that everyone has a belief in God or a higher power. It is, however, important to make sure that nonreligious people can respond to religious coping items as many may indeed turn to a higher power during periods of severe illness despite not admitting to believing in a God.

The Religious Activities Scale [43] includes six sub-scales: (1) spiritually based (e.g., "Trusted that God would not let anything terrible happen to me"); (2) good deeds (e.g., "Tried to be less sinful"); (3) discontent (e.g., "Felt angry with or distant from God"); (4) religious support (e.g., "received support from clergy"—note, not a coping strategy, rather, its consequence); (5) plead (e.g., "Asked for a miracle"); and (6) religious avoidance (e.g., "Focused on the world to come rather than on the problems of this world"). The items from the scale loaded onto six separate factors during development, and the sub-scales had Cronbach's alpha scores from poor (0.61) to excellent (0.92).

The RCOPE [20] is the most comprehensive measure to date. It includes 21 sub-scales (see Table 8.1 for examples of items from each sub-scale and Table 8.2) and is a theoretically based measure that examines much more wide-ranging religious coping methods, including potentially harmful religious expressions. It examines the functional aspects of religious coping and attempts to answer how people make use of their religion or spirituality to understand and deal with a stressful event which includes the five key religious functions in coping mentioned earlier (e.g., to gain meaning, control, comfort, and intimacy and to achieve a life transformation). It is, however, very long (105 items), but the authors recommend that researchers can pick sub-scales of interest or pick sub-scales that are relevant to the research purpose and can use three items (instead of five) with the highest loadings from each sub-scale (as indicated by the authors). The RCOPE was originally validated by Pargament et al. [20] using a college sample (five items per sub-scale) and a hospital sample (three items per sub-scale). The psychometric properties of the former, based on a 17-factor solution, were found to be acceptable with a Cronbach's alpha of 0.80 or greater for all but two scales: "marking religious boundaries" and "reappraisal of God's power," which had an alpha score of 0.78. The psychometric properties of the latter study, using a hospital sample, were also found to be acceptable showing alpha levels of 0.75 or greater for most factors.

Studies have found that several religious coping methods are moderately intercorrelated [19]. Therefore, specific clusters or patterns of religious coping strategies have more recently been explored using the Brief RCOPE [19]. This means that people do not make use of specific religious coping methods alone but apply them in some combination. Items are divided into positive and negative religious coping patterns (i.e., two sub-scales) and may be useful if researchers are interested in focusing on several methods and how these relate to outcome, rather than focusing on one method in detail [19]. All of the items from this scale can be found within the sub-scales of the RCOPE. The negative sub-scale includes items measuring spiritual discontent, punishing God reappraisal, interpersonal religious discontent, demonic reappraisal, and reappraisal of God's powers (see Table 8.2) and have all been empirically examined and associated with negative outcomes in the USA [25]. The positive sub-scale includes items measuring spiritual connection, seeking spiritual support, religious forgiveness, collaborative religious coping, benevolent religious reappraisal, and religious purification. Again, all these sub-scales have been empirically associated with positive outcomes in the USA [25]. During development, the Brief RCOPE showed a clear two-factor structure and acceptable alpha scores of 0.87 (positive sub-scale) and 0.78 (negative sub-scale). However, considering the current lack of research outside of the USA, one potential problem with this approach is that it makes a priori assumptions about which religious coping strategies are adaptive and which are maladaptive rather than treating this as an empirical question. Also, some items may not be as relevant outside of the USA. For example, demonic religious reappraisal (e.g., "Decided that the devil made this happen")

may seem alien to many people in Western Europe [44]. This combination of items may therefore not translate well to other cultures.

Finally, and more recently, the Religious and Spiritual Struggles Scale [45] was developed to examine the negative aspects of religious coping only. It has 26 items along 6 different domains: *divine* (negative emotions about God and the relationship with God); *demonic* (concerns about the influence of the devil or evil spirits); *interpersonal* (concerns about negative experiences with religious people or institutions); *moral* (worry or guilt about perceived offences); *doubt* (questioning one's religious/spiritual beliefs); and *ultimate meaning* (not perceiving much meaning in one's life). Using a student sample, the psychometric properties of this scale were found to be acceptable showing Cronbach's alpha scores from 0.80 to 0.96.

Most of these scales were developed on Christian populations and often use terms such as "church attendance" which may not be applicable to all patients with cancer. However, researchers can substitute these with more neutral terms such as "religious/spiritual service attendance" if patients from different religions or spiritual leanings are included in studies. It may also be necessary to ask patients to substitute the word God for a term they are more comfortable with (e.g., a higher power, the universe, spiritual force, etc.). Indeed, my colleagues and I have found that most patients from a variety of cultural backgrounds and religious/spiritual affiliations have no problem responding to these types of questionnaires when these minor adaptations are made.

Prevalence of Religious Coping in Cancer

Studies have reported that religious coping is one of the most commonly used coping strategies in the US cancer patients where up to 85% of women with breast cancer indicate that religion helped them cope with their illness [46]. Negative religious coping strategies on the other hand are used less often [20, 47, 48]. Fitchett et al. [48] found that only 13% of patients used "reappraisal of God's powers" in the coping process. However, religious/spiritual beliefs and practices are very different across cultures, and these findings may therefore not generalize to cancer patients outside the USA; 75% of North Americans feel God is important in their lives compared with 49% of people in Europe; 45% attend a place of worship regularly in the USA in contrast to 10% in the UK [49, 50]. In the USA, only 7% of the population are reported to be atheists [51] compared with 33% in the UK [52]. Indeed, Harcourt et al. [53] found that only 23% of the UK patients with breast cancer used religion in coping 8 weeks after diagnosis. However, this study examined religious coping in a simplistic way (e.g., by using generic questions from the Brief COPE) [37].

My colleagues and I examined various specific religious coping strategies (taken from the RCOPE), and we found a very different pattern; the use of nonreligious coping strategies was, overall, more common and religious coping, despite being used by 66% of the sample, was one of the least used coping strategies when assessed using a comparable general coping measure [54]. This is probably due to a much larger proportion of nonreligious/spiritual people in the UK. Indeed, 28% of patients in our study reported not having a belief in God or being unsure of God's existence. Using items from the RCOPE, we also found consistently high levels of positive religious coping strategies throughout the first year of illness. For example, "active and positive religious coping" was the most common religious coping strategy (with 73% of the sample using it to some degree at surgery), where patients attempted to find meaning, a sense of control, comfort, and intimacy in their illness. This was followed by coping methods to achieve a life transformation (used by 53% of the sample), where patients used religious coping to find a new purpose in life. Indeed, the majority of patients used active nonreligious coping by taking actions to try and make their situation better. It is therefore not surprising that the proportion of the sample who considered themselves religious/spiritual also used their religious/spiritual resources to achieve this. In contrast, negative

religious coping strategies were, overall, relatively less common. These findings support previous US results as well as a German study, where negative religious coping strategies were found to be overall less common than positive religious coping [20, 45, 47, 48]. However, despite being less common, negative religious coping strategies were used by as many as 53% of patients (e.g., reappraised God's powers). In addition, 37% of the sample felt, to some degree, punished and abandoned by God. This number is much higher than those reported by the US studies and may reflect the secular nature of the UK where God and religion may be viewed in more negative terms by those not practicing their faith in a more organized manner and may, as a result, have a less secure relationship with a God or may be struggling with their faith in their search for significance during periods of stress.

Change in Religious Coping Strategies Across the Illness Course

According to the "mobilization hypothesis" [55, 56], under stressful circumstances (e.g., a health threat), people are more likely to turn to their faith for coping in response; yet there is inconsistent evidence in cancer patients that this is the case [57]. There are also inconsistencies regarding how religious coping changes during the illness course in cancer. Using a general simple measure of religious coping, Carver et al. [58] and Culver et al. [59] found that religious coping decreased over time. In contrast, Alferi et al. [31] found that levels of religious coping ("extent of turning to religion for comfort") remained stable across a 12-month period. Other studies have examined the trajectory of religious coping across a range of specific religious coping strategies in cancer patients (breast cancer) [54, 60]. Gall et al. [60] found various patterns of change during the first 2 years of illness in ten specific religious coping strategies from the RCOPE. "Active religious surrender" and "spiritual support" showed an increase pre-surgery, and then a steady decline at follow-up. "Religious helping," on the other hand, increased from pre-diagnosis to 1-week pre-surgery but remained stable from pre-surgery throughout 2 years post-surgery, while "religious direction" increased pre-diagnosis to pre-surgery, followed by an increase until 6 months post-surgery, where it stabilized. "Religious focus" increased from pre-diagnosis to pre-surgery and from 1 to 6 months post-surgery, followed by a decrease from 6 months to 1 year. Other religious coping strategies such as "passive religious deferral," "spiritual discontent," "pleading," "benevolent religious reappraisal," and "collaborative religious coping" all remained stable. The pattern of change may therefore depend on the type of religious coping that is used.

My colleagues and I [54] compared the use of specific religious coping strategies in the UK in patients with early-stage breast cancer at the time of surgery and examined how these changed in the first year of illness. In support of previous findings by Alferi et al. [31], we found nonsignificant changes in four of the more specific religious coping strategies from the RCOPE; "religious coping to achieve a life transformation"; "passive religious deferral"; "reappraisal of God's powers"; and "pleading for direct intercession." Gall et al. [60] also found that "passive religious deferral" and "pleading" remained stable across time. However, they found significant changes in "seeking religious direction" (included in the "religious coping to achieve a life transformation" sub-scale in this study as they loaded together onto one factor) where it increased in use until 6 months post-surgery when it stabilized. This demonstrates that findings from one culture may not generalize to another. We also found a significant reduction in some religious coping strategies across time; "active and positive religious coping" and "seeking support from religious leaders and members of religious group" were significantly higher at the time of surgery than at follow-up. This suggests that patients were significantly more likely to seek support from God, actively surrendering to the will of God; work together with a benevolent God to solve problems; and seek support from religious/spiritual leaders and members of religious/spiritual groups in the early stages than fur-

ther into the illness course. The value of emotional support in patients with breast cancer is well established and appears to have the strongest associations with illness adjustment [61, 62]. For those with a close attachment to God, asking God for support could serve as an added support resource or even a support substitute. Seeking support from God or from religious/spiritual leaders/members early in the illness course is therefore not surprising considering the potential difficulties associated with a breast diagnosis and subsequent surgery. Indeed, Gall et al. [60] also found higher levels of seeking spiritual support early in the illness course. However, in our study, religious struggles such as "feeling punished and abandoned by God" and "searching for spiritual cleansing" were both significantly higher at surgery and 12 months compared with 3 months post-surgery. Gall et al. [60] found no change in spiritual discontent coping strategies across time (combined in our study with "punishing God reappraisal" as these loaded together onto one factor). Finally, the generic religious coping subscale from the Brief COPE only demonstrated that religious coping strategies were more common earlier in the illness course, confirming its limited usefulness as a measure of religious coping.

The above findings provide partial support for the mobilization hypothesis. Indeed, increasing the use of religious/spiritual resources in the coping process, when faced with uncertainties about the future after a cancer diagnosis, may be the case. The majority of our participants were unaware of their prognosis at baseline assessment. Religious coping may therefore be higher as a result and may decrease as the patients become aware of the good prognosis that is associated with early-stage breast cancers. However, the mobilization hypothesis does not explain why some religious coping strategies showed a tendency to increase at 12 months. Indeed, patterns of change may depend on the type of religious coping strategy that is used, and some of these may be particularly volatile. They are also likely to be influenced by co-occurring life events. The Cognitive Phenomenological Theory of Stress and Coping by Lazarus and Folkman [63] describes coping as process-orientated that is directed toward what an individual thinks and does within the context of a specific encounter and how these thoughts and actions change as the encounter unfolds. During the first year of cancer treatment, patients with breast cancer often undergo lengthy treatment protocols with distressing side effects and regular medical surveillance, and worries about treatment and cancer recurrence are common [64]. The postoperative period is one of recovery from the procedure but also of confrontation with, and adaptation to, loss and possible death [65]. It is likely that, as a result of searching for spiritual cleansing through religious actions earlier in the illness course, a need to repent or feelings of being punished and abandoned by God may no longer be salient a few months later. However, as a result of being under close surveillance by hospital staff, this care and attention may serve to substitute feelings of being abandoned or punished and may reduce efforts of religious purification. As this close level of attention is reduced around 12 months, negative feelings of being punished and abandoned, and a need for religious purification, may resurface as a reaction to the loss of care. There is related evidence that end-of-treatment distress may occur as a result of patients feeling vulnerable to tumor recurrence, as they are no longer monitored closely by hospital staff [66]. Indeed, patients may experience a loss of security from having treatment and loss of support relating to ongoing communication with healthcare providers [67–69]. What is clear from these findings is that cancer patients have different spiritual needs at different times during their illness course depending on their coping appraisals.

Cultural and Denominational Differences

It is important to note that specific religious coping strategies may vary between different ethnic groups and religious affiliations; Alferi et al. [31] found that US Evangelical women with breast cancer reported higher levels of church

attendance and religiosity across a 12-month period post-surgery compared with Catholic women. Religious denominations may also differ in the extent to which they focus on supporting and fostering the emotional well-being of their members and in their focus on the expiation of guilt and the preparation for the hereafter [31]. There may also be differences between those who are affiliated and those who are not in how they use religious coping strategies. There is evidence that non-affiliates are less likely to express "religious consolation," that is, seeking spiritual comfort and support. Religious affiliates, on the other hand, are more likely to be exposed to support by religious group members and rituals which may enhance the use of positive religious coping [70]. However, one cannot assume that those reporting an affiliation with a particular religious denomination actually practice their faith, as they may simply be referring to their identity rather than their religious involvement, especially in countries such as the UK where regular religious service attendance is relatively low. Therefore, establishing that religious affiliation refers to the actual practice of faith is vital.

There may be differences between those who are affiliated (e.g., Catholic, Protestant) and those who are not (e.g., those who believe in God but do not see themselves as belonging to a particular denomination) in how they use religious coping strategies. There is evidence that non-affiliates are less likely to express "religious consolation," that is, seeking spiritual comfort and support and are less likely to be connected to religious groups and therefore less likely to use religious coping strategies, even in the light of a serious illness such as cancer. Religious affiliates, on the other hand, are more likely to be exposed to rituals which may enhance the use of religious coping [70]. In addition, in countries where a large proportion of the population do not believe in a God, it is important to include all patients in studies examining religious coping, as "non-believers" may nevertheless use religious coping during difficult and desperate times, just as those who believe may exclude their faith in the coping process [54].

There is also evidence that relying on faith during illness in the USA is also greater in some groups such as African Americans [71–73] and Hispanics [36] compared to Caucasians [59, 74]. Indeed, one study found that Black men in the USA with prostate cancer used positive religious coping more often than white men [75].

Religious Coping and Adjustment in Cancer

Various religious coping strategies adopted by people and how these change during the illness course have implications for illness adjustment in cancer [44, 60, 74]. Indeed, there is increasing evidence of the importance of drawing on religious/spiritual resources in the coping process during illness. However, few studies have adequately examined these in patients with cancer, especially outside the USA [76]. A systematic review published in 2006 examining the relationship between religious coping and cancer adjustment found that many studies report mixed findings, but most have various methodological shortcomings using, for example, mixed cancer groups at different stages of their illness [76]. This makes it difficult to discern the impact of the relationship between religious coping and time, as it is possible that at crucial times during the illness course, patients may rely more on their religion/spirituality as they adapt to their diagnosis, treatments, and an uncertain future. Another issue is how religious coping has been conceptualized and measured. However, the potential confusion between religious coping cognitions versus behavior such as religious service attendance is particularly important in societies with high religious service attendance, where an effect could be caused by perceived social support from the religious community rather than religious coping. Many studies have also used generic instruments (e.g., the Brief COPE [37]) that do not identify the content of prayer or the specific religious coping strategies used. Only three studies used measures developed specifically to examine religious coping [77–79], all of which produced significant results in the expected direction.

Since the review was published, further studies have been conducted examining the efficacy of religious coping on well-being in patients with cancer [44, 47, 48, 60, 74, 75, 80–86]. These additional studies reinforce the suggestion that when better ways of measuring religious coping are used, more significant findings are evident. Particularly noticeable is the consistent relationship between negative religious coping and poorer outcomes. However, all of the above studies except Derks et al. [81], Hebert et al. [84], Sherman et al. [85], Gall et al. [60], and Gall [87] were cross-sectional in design, and most (except Gall et al. [60]) used the Brief RCOPE to measure religious coping. Some had very large refusal rates or attrition [44, 74, 81]. Five were conducted outside the USA and found the effects of religious coping to be comparable [44, 60, 81, 83, 86]. Although some controlled for demographic and medical variables [47], only one study [84] controlled for the potential confounding effect of perceived social support.

The Role of Nonreligious Variables

Studies examining religious coping in cancer using more appropriate measures have rarely assessed the role of other important psychological variables (e.g., perceived support, nonreligious coping, and optimism) and how these features in explaining the link between religious coping and adjustment. For example, Gall [80] and Sherman et al. [47] used regression analysis to assess the efficacy of religious coping in predicting adjustment. These studies controlled for demographic variables and found a significant independent effect of religious coping (Brief RCOPE) on adjustment. However, it is not known how these significant effects would appear if other variables known to affect adjustment in patients with cancer had been entered into the regression model. Indeed, researchers need to be thoughtful about which other variables should be measured alongside religious/spiritual variables and consider the order in which these are entered if regression analysis is used. Entering religious coping strategies last, after other nonreligious variables, can only produce two results: an independent effect or a nonsignificant effect of religious coping. If a mediating effect has occurred, it would not be visible; rather a nonsignificant finding would be evident leading to a false conclusion.

Few studies have examined the mechanism through which religious coping affects outcome in patients with cancer. However, there is evidence from non-cancer studies that perceived social support is correlated with various religious factors such as church attendance, church membership, subjective religiosity, religious affiliation [88], and even private religious practices such as prayer [89]. Indeed, perceived social support as well as hope and optimism were found to completely mediate the effect of positive religious coping on better adjustment in cardiac patients [90–92]. Other studies have found inconsistent results. For example, Koenig et al. [89] found that religious activity as a single construct was correlated with social support but was unrelated to depression in a sample of patients over the age of 65. In the same study, frequency of church attendance was negatively related to depression but was surprisingly unrelated to social support. Private prayer was, however, positively related to social support but unrelated to depression. In addition, Bosworth et al. [93] found that social support was related to lower levels of negative religious coping strategies (Brief RCOPE) in a geriatric sample, but negative religious coping was independently related to lower levels of depression. They also found that public religious practice was related to social support but independently related to lower levels of depression in the regression analyses once social support was controlled for.

There are cancer studies examining how religious/spiritual resources other than religious coping strategies are linked to outcome (e.g., religious involvement, strength of faith, or levels of religiosity/spirituality). For example, Sherman and Simonton [94] found that optimism played a mediating role in the relationship between general religious orientation and psychological adjustment in patients, but social support did not seem to play a comparable role. Sherman et al.

[94] found that strength of faith was related to optimism but not to social support. However, Carver et al. [58], using a generic measure of religious coping (the Brief COPE), found that religious coping in patients with breast cancer was not related to optimism at any time point of assessment. This suggests that how religiousness/spirituality is operationalized and measured determines how and whether it is significantly related to outcome.

Various religious coping strategies are also both positively and negatively related to nonreligious coping strategies such as active coping, suppressing competitive activities, planning, the use of social support [58], positive reinterpretation and growth [36], positive and negative appraisal of the cancer situation, distancing coping and focusing on the positive, seeking support, behavioral avoidance, cognitive avoidance, and focusing on the positive [77]. Qualitative work has also found a link between humor and spirituality [95]. Indeed, there is evidence that active coping mediates the link between religion/spirituality and functional well-being in patients with ovarian cancer [96] and between religious involvement and psychological distress in patients with HIV [97]. In addition, religious/spiritual beliefs have been shown to have a positive association with active rather than passive nonreligious coping strategies in cancer patients [98, 99], and those who have strong religious/spiritual beliefs are more likely to use cognitive reframing (i.e., focusing on the positive) as a coping strategy during cancer [100].

There is also evidence of a mediating role of nonreligious variables between religious coping and adjustment in patients with cancer [44, 101]. For example, Zwingman et al. [44] found a mediating effect of nonreligious coping between positive and negative religious coping and psychosocial well-being. They also found that negative religious coping moderated the effect of religious commitment and anxiety. The second study was conducted by my colleagues and I. We examined the role of various specific religious coping strategies on anxious and depressed mood [97]. Previous studies have tended to find negative religious coping, as measured by the Brief RCOPE, to be related to higher levels of anxious mood in patients with cancer [44, 47, 48, 83, 85]. As mentioned earlier, this 7-item sub-scale clusters together various negative religious coping strategies. It is therefore not known which negative religious coping strategy is responsible for this effect. We were indeed able to demonstrate which negative religious coping strategy was important in predicting anxiety in patients with breast cancer living in the UK and also how religious coping was related to this mood variable. First, it appeared that feeling punished and abandoned by God significantly explained 5% of the variance in higher levels of anxiety, but this effect was partially buffered by acceptance coping, reducing levels of distress. The effect of feeling punished and abandoned by God on anxiety was also partially mediated by denial coping, which was significantly associated with higher levels of anxiety. This suggests that a "negative" religious coping strategy can be associated with both higher and lower levels of anxious mood depending on which combination of nonreligious coping strategies is used and shows that religious coping may be related to outcome in more complex ways. Referring to it as a negative religious coping strategy could therefore be misleading in some instances. These findings also reject the usefulness of clustering questionnaire items based on a priori assumptions of which coping strategies are negative and which are positive.

Previous findings have also demonstrated that negative religious coping strategies are associated with higher levels of depressed mood in patients with cancer [44, 47, 48, 85]. However, as with anxiety, most previous studies have used the Brief RCOPE to examine negative religious coping in relation to depression. It is therefore currently not known which negative religious coping strategy is responsible for this effect. In our study, "feeling punished and abandoned by God" was an independent predictor of depressed mood explaining 4% of the variance. We also found that self-blame coping was the only nonreligious coping strategy to predict higher levels of depressed mood and was responsible for 5% of the variance. This demonstrates that religious coping was of equal importance to nonreligious coping

in predicting depressed mood in patients with breast cancer in the UK. It is important to mention, however, that these analyses were cross-sectional, so we cannot infer causality at this stage. It is, for example, possible that depressed mood may cause people to appraise their situations within a negative religious framework.

We were unable to find a significant effect of positive religious coping on adjustment in patients with breast cancer. Similar and mixed results in cancer populations are seen elsewhere [44, 47, 85]. The reason for inconsistencies is not yet clear, and the presence or the absence of an effect may simply be due to difficulties in selecting the right outcome measure. Positive religious coping strategies may, for example, be more likely to be related to positive outcomes such as positive affect and life satisfaction. It is also worth mentioning that different patterns of religious coping and how these relate to various adjustment outcomes may be expected from different ethnic groups with different religious backgrounds. For example, the literal meaning of "Islam" means submission and peace which is found by accepting the will of God and accepting events that are outside of our control. For this reason, Islamic theology does not accept anger toward God as an acceptable response to suffering [102]. Currently, more research is needed to understand ethnic differences in relation to religious coping and psychological well-being.

In our studies, perceived social support did not play an important role in explaining how religious coping is associated with adjustment variables. Indeed, previous studies have found inconsistent evidence of social support as a mediator between religious/spiritual resources and adjustment. This inconsistency raises more questions than answers. There is some evidence that church attendance and seeking support from a priest/minister are more advantageous in some denominations. For example, there is evidence that it is beneficial for Evangelical women, but detrimental for Catholics, and that obtaining emotional support from church members is related to less distress in Evangelical women only [31]. Differentiating between the sources of perceived social support may be important as these sources may serve different support functions with different types of consequences. Perhaps a support measure needs to be more explicit regarding which type of support it is measuring, that is, specifically examine support from religious/spiritual communities. However, this is problematic in studies assessing support in a large proportion of individuals who simply do not belong to a religious community (e.g., a European sample). Future studies, especially in the USA, may nevertheless attempt to be more specific in terms of how they enquire about patients' perceived support and examine specific support from religious/spiritual communities using a measure designed specifically for this purpose [103].

Religious Coping and Growth

Until recently, research had largely focused on the negative consequences of a cancer diagnosis (e.g., negative mood) [104]. Indeed, many cancer patients experience clinical levels of distress and dysfunction including anxiety and depression, and some may even suffer from post-traumatic stress disorder [105, 106]. However, there is evidence that cancer should not be viewed as a stressor with uniformly negative outcomes but rather as a transitional event which may create the potential for both positive and negative change [107, 108]. Despite the stress of coping with a cancer diagnosis and dealing with often lengthy treatment protocols, many patients are able to find meaning in their illness such as experiencing profound positive changes in themselves, in their relationships, and in other life domains after cancer [109]. It is even suggested that finding meaning in a stressful event is critical for understanding illness adjustment [110].

Researchers have used a number of terms to describe individual reports of finding meaning in the face of adversity [111]. These include related concepts such as "benefit finding" [104, 112], "stress-related growth" [113], "post-traumatic growth" [114], and "gratitude" [115, 116]. Post-traumatic growth has been defined as "positive psychological change experienced as a result of

the struggle with highly challenging life circumstances" [111]. Benefit finding has been described as "the pursuit for the silver lining of adversities" [104], while gratitude has been defined as "the willingness to recognize the unearned increment of value in one's experience" [117]. Although these concepts are similar and related to a large extent, gratitude is considered a broader concept while benefit finding, stress-related, and posttraumatic growth are seen as examining more specific aspects of growth and positive changes arising from a stressful event [118].

Finding meaning in the cancer experience in the form of positive benefits is a common occurrence [119]. There is also evidence that a higher level of faith/religiousness is linked to greater levels of perceived cancer-related growth and benefit finding [114, 120, 121]. However, very few studies have examined the link between religious coping and growth/benefit finding in patients with cancer although some have provided some insight using the Brief COPE. For example, studies have found that patients with breast cancer scoring high on religious coping also scored high on growth [122, 123], and religious coping pre-surgery has also been found to predict higher levels of growth 12 months later in patients with prostate cancer [124]. My colleagues and I, however, addressed which aspects of religious coping may facilitate growth. We used a prospective study examining the effects of religious/spiritual coping resources on benefit finding in breast cancer along with other potentially influencing variables such as nonreligious coping, optimism, and social support [125]. We found that religious coping to achieve a life transformation predicted 14% of the variance but was partially mediated by strength of faith. Strength of faith at surgery on the other hand was an independent predictor of benefit finding 3 months later, predicting 6% of the variance. Seeking emotional support coping at surgery was the only nonreligious variable to predict outcome, explaining 3% of the variance in higher levels of benefit finding 3 months later. Our results show that religious coping was far better than nonreligious coping or indeed, other psychological variables, in predicting a positive outcome such as benefit finding. Again, this study highlights the importance of examining religious/spiritual resources in combination with other variables to fully understand their relationship to adjustment in cancer.

Addressing Cancer Patients' Spiritual Needs

Assessing the psychological needs of patients with cancer has become commonplace in clinical practice in recent years. Also, as a result of studies showing social support to be important in the adjustment process, providing support groups for those patients lacking in support is also widespread. Addressing patients' spiritual concerns is also, in relative terms, commonplace within palliative care, but, as research shows, spiritual concerns can occur at any time during the cancer course. However, how and whether religious/spiritual concerns should be addressed in patients with serious illness has been much debated [126, 127]. Indeed, some academics/physicians believe that there is no place for religion/spirituality within medicine [127, 128]. Then again, critics often fail to differentiate between subjective religiousness/spirituality studies (e.g., spiritual beliefs and behaviors) and those of an objective approach examining, for example, the effect of intercessory prayer on recovery where patients in the experimental group are usually not aware they are being prayed for. Intercessory prayer studies do not examine the effect of patients' own cognitions and behaviors in relation to outcome such as psychological well-being or quality of life but attempt to test the existence of God through the power of prayer. These studies are therefore not psychological in nature; rather they belong within the theological realm. A psychological study assesses the effect of patients' own *subjective* beliefs, perceptions, and behaviors on outcome. Often, these two types of studies are discussed together as if they were, in some way, comparable. It should be mentioned, however, that the effect of intercessory prayer can be important if, during a difficult time, a person is aware of others praying for him or her, as it can

instill a sense of comfort from communal caring, and may reinforce a sense of belonging and personal worth in relation to significant others [129]. In addition, when critics discuss patients' subjective religious/spiritual beliefs and practices in relation to health as being problematic, the focus tends to be on the efficacy of religious/spiritual practices such as prayer in assisting with the physical recovery from disease. Prayer in this case is a form of alternative therapy, where it is used as a substitute for conventional medicine. In this instance, religion/spirituality may have severe implications for recovery [128]. If there is evidence of a conflict between religious beliefs and recommended treatments, the National Comprehensive Cancer Network's (NCCN) clinical practice guidelines in oncology—distress management [130]—describe how to deal with this issue. Indeed, Koenig [131] argues that if religious/spiritual resources serve to influence medical decision-making in powerful, negative ways, these need to be understood.

It is suggested that an understanding of patients' religious/spiritual foundation can guide appropriate care [132]. If religious coping turns out to be helpful or even harmful to patients, it may be beneficial for healthcare professionals to acknowledge and support patients' spirituality or religious leanings [133]. For example, patients who perceive their illness as a punishment may become unable to use their faith as a coping resource. God may be seen as weak, distant, or uncaring which may lead to an existential crisis. Plotnikoff [134] has provided a few specific examples of spiritual struggles and their implications: (1) spiritual alienation ("Where is God when I need him most? Why isn't God listening?"); (2) spiritual anxiety ("Will I ever be forgiven? Am I going to die a horrible death?"); (3) spiritual guilt ("I deserve this. I am being punished by God. I didn't pray often enough."); (4) spiritual anger ("I'm angry at God. I blame God for this. I hate God."); (5) spiritual loss ("I feel empty. I don't care anymore."); and (6) spiritual despair ("There is no way God could ever care for me."). However, deciding how to best respond to a patients' spiritual needs can raise professional and ethical issues for healthcare professionals about how they interact and deal with patients [126]. For example, should health professionals really discuss spiritual issues with patients and do patients want them to? If so, who is best placed to do this and what should the professional boundaries be between healthcare professionals and chaplains?

There is some evidence suggesting that addressing spiritual concerns with a physician appears to have a positive impact on perception of care and well-being in patients with cancer [135, 136] and may enhance recovery from illness [137] and improve quality of life [138–140]. Further, 65% of non-cancer patients in a US pulmonary outpatient clinic said that if physicians enquired about spiritual beliefs, it would strengthen their trust in their physician [141]. Therefore, having clinical respect for patients' spirituality as an important resource for coping with illness is important. In the USA, between 58% and 77% of hospitalized patients want physicians to consider their spiritual needs [142, 143]. Further, 94% of patients want their physicians to ask about their religious/spiritual beliefs if they become gravely ill [141], and 45% of patients who did not have religious/spiritual beliefs still felt it appropriate that physicians should ask about them [144]. However, Koenig et al. [145] also found that up to one-third of the US patients do not want physicians to discuss spiritual issues with them. Therefore, physicians (or other healthcare professionals such as a nurse) may initially explore patients' general coping methods in order to discover whether their religious/spiritual beliefs play an important role in their medical decisions.

Most studies examining religious/spiritual needs in patients with medical illnesses have been conducted in the USA. There is some evidence from a German study that the majority of patients who were asked wanted their doctor to be interested in their spiritual orientation [146]. The proportion of patients in other European countries who want their spiritual needs assessed and how these issues should be addressed and by whom is unclear. However, a recent systematic review of the European literature exploring spiritual care within palliative care in general found positive effects of spiritual care, yet the empirical evidence for its efficacy remains low [147].

Spiritual Needs Assessments

A spiritual assessment may contain numerous questions about religious denomination, beliefs or life philosophies, important spiritual practices or rituals, the use of spirituality or religion as a source of strength, being part of a faith community of support, the use of prayer or meditation, loss of faith, conflicts between spiritual or religious beliefs and cancer treatments, ways that healthcare providers and caregivers may help with the patient's spiritual needs, concerns about death, and the afterlife and end-of-life planning [148]. There are several tools in existence that attempt to address patients' spiritual needs (see Table 8.3). These have been developed mainly by the US researchers and provide guidelines on how to conduct a spiritual history. The earliest is the Kuhn's Spiritual Inventory [149]. This brief assessment tool enquires about religious/spiritual beliefs, how illness has influenced beliefs, how patients exercise their beliefs in their lives, and how faith has influenced their behavior during illness and regaining health. Further, Matthew and Clark [150] suggest that physicians should ask about three fundamental questions as part of the initial evaluation. Their assessment tool—the Matthew's Spiritual History—examines the importance of spirituality to the patient, how this influences the way they look at their medical problem/think about health, and whether they would like the physician to address these issues. A similar tool is the FICA Spiritual Assessment Tool [151] which, again, addresses patients' religious/spiritual traditions, the importance of faith, how it is practiced, how it is applied to health and illness, and how these should be addressed. Another much more thorough instrument is the Maugans's SPIRITual History [152]. This covers six areas (SPIRIT): the *s*piritual belief system (e.g., affiliation), *p*ersonal spirituality (includes accept-

Table 8.3 Instruments providing guidelines on how to take a spiritual history, thereby addressing patients' spiritual needs

Authors	Measures	Description
Kuhn [149]	Kuhn's Spiritual Inventory	Meaning, purpose, belief, faith, love, forgiveness, prayer
Matthews and Clark [150]	Matthew's Spiritual History	Importance and influence of religious beliefs and practices and desire of physician addressing these
Puchalski [151]	FICA Spiritual Assessment	FICA: F, faith – what tradition; I, importance of faith; C, church – public religious practices; A, apply – how these apply to health and illness; and A, address – how these should be addressed
Maugans [152]	Maugans's SPIRITual	Includes six areas (SPIRIT): the spiritual belief system, personal spirituality, integration within a spiritual community, ritualized practices and restrictions, implications for medical care, and terminal event planning
Anandarajah and Light [154]	HOPE Questionnaire	Source of hope, meaning and comfort, organized religion, personal spirituality and practices, the effect of these on medical care and illness, and how these should be addressed
Lo et al. [155]	ACP Spiritual History	Includes four questions: The importance of faith, when and for how long, availability of someone to talk to about religious/spiritual matters, and whether the patient wants to explore issues with someone
Frick et al. [146]	SPIR	A semi-structured interview assessing 4 main areas: belief/spirituality/religiosity of patients; the place of spirituality in patient's life; integration into a spiritual community; preference of the role of healthcare professionals in dealing with spirituality
Büssing et al. [157]	Spiritual Needs Questionnaire (SpNQ)	19 items assessing religious needs (e.g., praying), inner peace, existential (reflection/meaning), and actively giving
van Bruggen et al. [158]	Existential Concerns Questionnaire (ECQ)	22 items measuring death anxiety, intolerance of uncertainty, neuroticism, distress, meaning, life events
Exline et al. [45]	The Religious and Spiritual Struggles Scale	26 items examining 6 domains of struggle: divine, demonic, interpersonal, moral, doubt, ultimate meaning

ability of beliefs and practices), *i*ntegration within a spiritual community, *r*itualized practices and restrictions, *i*mplications for medical care, and *t*erminal events planning. This is probably the most comprehensive tool to date covering the most important areas of spiritual needs [153]. Equally, the HOPE questionnaire [154] also examines a broad range of issues considered important in medical illness and decision-making: source of hope, meaning and comfort, organized religion (e.g., being a member of a religious community), personal spirituality and practices, the effect of these on medical care and illness, and how they should be addressed. Finally, the ACP Spiritual History tool [155] asks patients with a serious medical illness four simple questions: the importance of faith during their illness, the importance of faith at other times of their lives, the availability of someone to talk to about religious matters, and their need to explore religious matters with someone. This assessment is patient centered and brief. However, it fails to gather information in several key areas such as identifying spiritual needs, connection with religious/spiritual communities, and beliefs affecting medical decision-making. It was also developed for patients in a palliative care setting only.

It is important to reiterate that these tools were developed in the USA, and it is therefore not currently known to what degree these questions would be perceived as acceptable in the hospital environments of other countries and cultures. Indeed, the crisis of religious institutions is more noticeable in Western Europe than in the USA [146] where Davie et al. [156] have described the phenomenon of "believing without belonging." This means that religious/spiritual beliefs become increasingly personal, detached, and heterogeneous in nature, and this must be taken into account when patients' religiousness/spirituality is assessed in a European context [146]. However, two European (German) assessments exist: the SPIR, a semi-structured spiritual needs interview guide [146] that examines four main areas of patients' spiritual needs and how patients would describe themselves (e.g., a believer/religious/ spiritual), the place of spirituality in their lives, whether they are integrated into a spiritual community and the role they would like to assign their healthcare professional in the domain of spirituality.

The second is the Spiritual Needs Questionnaire [157] which is suited to both secular and religious societies and attempts to address four aspects of cancer patients' spiritual needs: the religious (e.g., praying with others or by themselves), inner peace (e.g., a need to find peace or dwell in a quiet place), existential (e.g., reflections about a previous life or the need to talk with someone about the meaning of life), and actively giving (e.g., to give away something of yourself). There is currently no data to assess its general usefulness. It is also important to appreciate that, after a cancer diagnosis, a nonreligious/spiritual person may, for example, interpret concepts such as finding meaning and purpose in existential or humanistic terms, while a religious/spiritual person would view the same construct as religious or spiritual in nature [157]. Nonreligious cancer patients may therefore have similar needs to religious/spiritual patients but may not label these as such. This may be especially prevalent in European cancer patients. Indeed, examining patient's existential needs may be more appropriate for such a sample. Existential anxiety (EA) is a construct that refers to fears that are provoked by core threats of human existence, such as death, meaninglessness, and fundamental loneliness [158]. Existential distress may be confined to distress that arises when the meaning and value of one's life is unclear and is comorbid with feelings of loneliness and low self-worth [159]. There is evidence that adult patients with cancer across all stages and types benefit from existential interventions [160]. Indeed, the most recent US NCCN guidelines [130] recommend the use of the Existential Concerns Questionnaire (ECQ) [158] in such instances.

Finally, the most recent NCCN guidelines [130] also recommend the use of the Religious and Spiritual Struggles Scale [45] to examine patient's spiritual needs. As mentioned earlier in this chapter, this 26-item scale measures spiritual struggles only, and it is currently not known how these items generalize to other non-US cultures

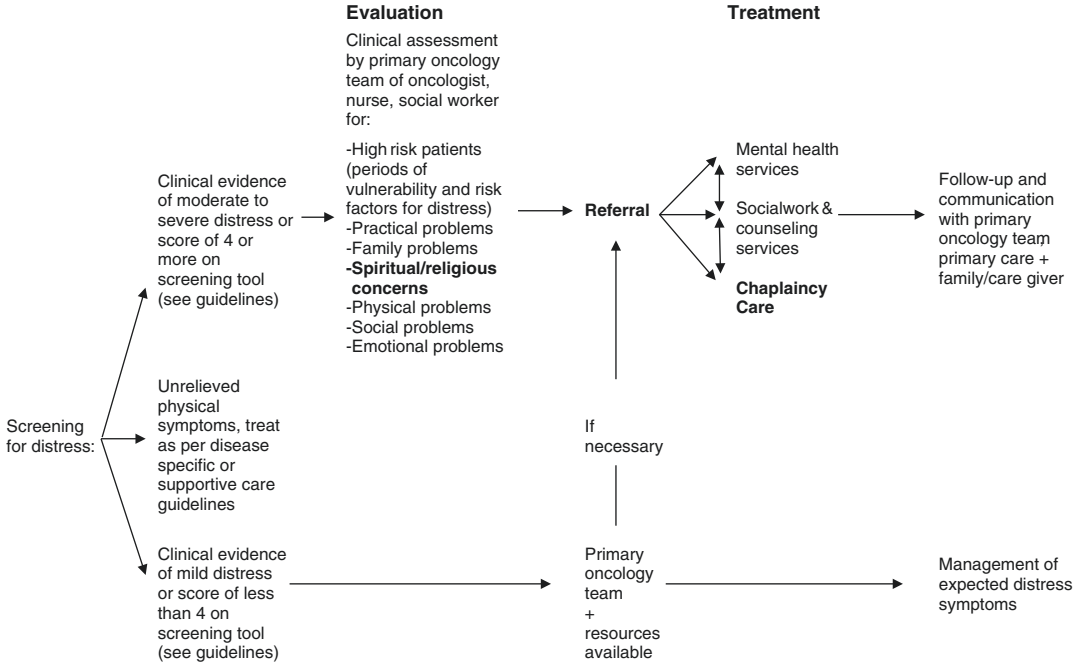
nor do we know how well its six domains are suitable for different religious traditions. It also does not inform about patient's religious/spiritual affiliation and history—past and present. It should therefore probably be viewed as an additional complimentary measure unless spiritual struggles are of interest only.

Spiritual Distress Management

It is suggested that negative events are easier to bear when understood within a benevolent religious framework. Indeed, the current findings show that positive aspects of religious coping may be related to better adjustment. Therefore, religious counselors, that is, hospital chaplains, can help by reframing negative events within the will of a loving and compassionate God and help patients (who show evidence of religious struggles) to utilize more effective religious coping methods. It has been suggested that this can help individuals to maintain a theologically sound understanding of suffering and to experience better mental health outcomes in terms of their psychological adjustment in the face of stressful events [134]. The UK National Institute for Clinical Excellence (NICE) guidelines on spiritual support services in cancer care [161] state that provider organizations should adhere to the framework of best practice in meeting the religious and spiritual needs of patients and staff outlined in the UK's NHS Chaplaincy Guidelines [162]. For example, on (or before) admission to hospital, patients should be asked whether they would like to have their religious affiliation recorded. They should be informed that this data will be processed for one or more specified purposes. Patients should be asked for permission to pass this information on to the chaplaincy service for the purposes of spiritual care. A staff member, usually a healthcare chaplain/spiritual caregiver, should be nominated to be responsible for liaising with local faith leaders. In addition, while recognizing that one individual may hold specific responsibility for ensuring the provision of spiritual care, this should also be seen as the responsibility of the whole team. Further, individual team members responsible for offering spiritual care should contribute to the team's regular review of care plans, especially for those patients with already identified spiritual needs. These guidelines also state that chaplaincy services should be available in the primary, secondary, and palliative care setting as well as in the community (e.g., home visits) and highlights the importance of including all religious and spiritual beliefs including those without.

In the USA, the NCCN's Clinical Practice Guidelines in Oncology—distress management [130]—also include very clear guidelines on how to manage spiritual distress. The initial evaluation process describes various pathways for screening for distress: the evaluations process, through to referral, treatment, and follow-up. For example, during the evaluation process, any indication of spiritual/religious concerns must be noted, and appropriate referrals made to pastoral services. However, their screening tool for measuring religious/spiritual distress asks only one very basic question, "Please indicate if any of the following has been a problem for you in the past week including today" followed by a yes/no answer for religious/spiritual concerns. Therefore, a more thorough tool (if time allows), such as those mentioned earlier in this chapter, may be implemented after the initial assessment. These assessments should also include a thorough exploration of patients' coping strategies.

Evidence described in this chapter shows that cancer patients' spiritual needs may vary depending on how their situation is appraised. For example, support from their religious community may be more important early on in the illness course while religious/spiritual struggles, although more prevalent in some cancers early on, may resurface much later when healthcare professionals are no longer involved in their patients' care to the same degree. This suggests that interventions should, overall, target patients early but that healthcare professionals should also be aware of the potential resurfacing of some religious struggles later on in the illness trajectory and that these need to be reexamined and addressed at regular intervals.



Barriers to Spiritual Needs' Assessment and Management

Addressing religious/spiritual concerns is not commonplace despite the US NCCN's [130] Clinical Practice Guidelines in Oncology and the UK NICE Guidelines [161] stating the importance of supporting patients' spiritual needs during the course of cancer. The UK Clinical Standards for Working in a Breast Speciality [163] further highlights the importance of understanding psychological risk factors associated with morbidity during breast cancer by understanding a variety of helpful or unhelpful coping strategies, being aware of spiritual conflicts, providing patients with appropriate emotional support and offering intervention strategies, for example, advice regarding coping strategies or referral to other agencies. However, a US study found that as many as 72% of patients with advanced cancer said that their spiritual needs were either minimally met or not met at all by the medical system and 47% said that they were supported minimally or not at all by their religious community [138]. However, healthcare professionals have expressed concern about lack of time, lack of skills (e.g., not knowing how to take a spiritual history), and the appropriateness of such discussions within the context of the medical encounter [143, 164, 165]. Indeed, in the USA, physicians' discomfort at addressing spiritual needs is the best predictor of whether these discussions take place or not [164]. It is also well established that religiosity/spirituality and a belief in God are much lower among physicians, healthcare professionals, and academics compared with their patients or with the general population [8, 166–173]. In the UK, around 70% of people have some belief in God [50]. However, a study examining religiosity among 230 psychiatrists working in London teaching hospitals found that only 27% reported a religious affiliation and 23% reported a belief in God [174]. Another study assessing religious faith in healthcare professionals at a London teaching hospital found that 45% of hospital staff reported that they had a religious faith [175].

There is also a higher level of atheism among physicians. Neeleman and King [174], for example, found that 25% of doctors reported that they were atheists compared to only 9.5% of their patients. Also, Silvestri et al. [176] found that cancer patients and their caregivers ranked doctor recommendations as most important followed by faith in God second, whereas physicians placed faith in God last. These lower levels of religiosity/spirituality and higher levels of atheism may lead healthcare professionals to underestimate the importance of faith for their patients and may also explain the lack of mainstream research in the area until recently. Indeed, physicians who report addressing patients' spiritual concerns do so because of their own spirituality and because of an awareness of the scientific evidence associated with spirituality and health. Empirical findings do suggest that barriers to spiritual assessment include upbringing and culture, lack of spiritual inclination or awareness, resistance to exposing personal beliefs, and the belief that spiritual discussion will not have an impact on patients and their lives [177–179]. It has also been suggested that faith may be a very personal matter for physicians due to the potential stigma associated with admitting being spiritual/religious [180]. Klitzman and Daya [180], using a qualitative methodology, examined spirituality in doctors who themselves had become seriously ill and found that they too had beliefs that ranged from being spiritual to start with; to being spiritual, but not thinking of themselves as such; and to wanting, but being unable to believe. Some continued to doubt. The contents of beliefs ranged from established religious traditions to mixing beliefs, or having nonspecific beliefs (e.g., concerning the power of nature). One group of doctors felt wary of organized religion, which could prove an obstacle to belief. Others felt that symptoms could be reduced through prayer. Unfortunately, there is no comparison data available for non-physicians suffering from a similar condition. However, understanding spiritual-cultural influences on health-related behaviors, and illness adjustment is essential if healthcare professionals are to provide effective care to their patients. Overcoming barriers is therefore important as it would allow a more accepting and open discussion about patients' lives beyond the social and the psychological. Nevertheless, many physicians still practice under the biomedical model where spiritual matters may seem less relevant [137].

There are also some practical problems in meeting patients' spiritual needs. For religious/spiritual counseling to take place, someone needs to identify patients with spiritual concerns in order to refer those who struggle with their faith to a degree that it is detrimental to well-being. Current UK guidelines [162] view hospital chaplaincy as central to this role. However, despite recommendations, chaplains may not be available in smaller hospitals or in outpatient clinics where most care is delivered, especially early in the cancer course where religious/spiritual issues may first arise [148]. In addition, patients struggling with their faith may not want to speak to hospital chaplains as they may feel alienated from religion and anyone associated with it [153]. Also, patients' spiritual concerns may not be "religious" in nature (in terms of organized beliefs and practices) but may take the form of existential and philosophical issues [181]. Therefore, having an intermediary trained to assess and deal with spiritual/existential issues may be more appropriate in the first instance. However, should more complex spiritual needs arise, or should patients wish to speak to religious/spiritual counselors, appropriate and agreed referrals could be made. In a country such as the UK, it may be more appropriate for a senior specialist oncology nurse (e.g., a breast care nurse) to deal with spiritual needs as these healthcare professionals are already trained to assess and address patient's psychological and social needs. Indeed, if patients who have turned away from institutional religion would prefer to talk to a healthcare professional about their spiritual needs rather than a trained and certified chaplain or pastoral counselor, there is a genuine need to provide adequate education and training to allow these professionals to competently address and uncover spiritual needs within this patient group [157].

Conclusions and Future Directions

The focus of this chapter has been on religious coping, its nature, measurement, prevalence, and how it relates to adjustment in cancer. The use of religiosity and spirituality in coping is indeed common in cancer patients throughout the illness course and not just in the USA but also in European cultures where the abandonment of organized religious institutions is much more prevalent. It is also increasingly clear that it plays an important role in illness adjustment, especially the use of negative religious coping strategies. With increasing evidence of its importance, there is an argument for introducing appropriate spiritual need interventions within oncology clinics. Indeed, addressing the psychosocial needs of patients with cancer has become routine in clinical practice in recent years. However, addressing religious/spiritual concerns is not commonplace despite recommendations. Barriers to why this may be the case should be highlighted and overcome and training is needed to allow healthcare professionals to have confidence in their ability to assess and address cancer patients' spiritual needs within clinical practice. There is also a need to develop and test spiritual needs interventions tailored to suit the environment in which they will be implemented. Few such interventions currently exist (but see Kristeller et al. [135]).

The relationship between religious coping and adjustment in cancer is complex [182]. Future studies should examine the mechanism through which various religious coping strategies operate on outcome by examining individual religious coping strategies rather than clusters of coping that has a priori assumptions of what is adaptive or maladaptive. Indeed, much more work is needed examining specific religious coping strategies and how these are linked to various outcomes by examining mediating/moderating relationships using longitudinal designs; studies should examine psychosocial variables in relation to religious/spiritual variables and cancer adjustment and should further explore the relationships between religious coping and positive outcomes. This may provide a clearer understanding of the importance of various religious coping strategies and to which outcome they are related to.

Although there is some evidence that religious coping is more often tied to psychosocial functioning than physical functioning in patients with cancer [94], other studies have found that negative religious coping (using the Brief RCOPE), after controlling for demographic and medical variables, is associated with significantly higher levels of pain and fatigue [47]. Future studies may like to examine the link between religious coping and physical functioning further and in a more thorough manner. In addition, very little is known about differences in religious coping across cancer stages and cancer types. There are also few studies available informing us about differences in religious coping across ethnic groups, different religious traditions, and religious affiliations and how these variables impact on illness adjustment.

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