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Religious Orientation and Coping with Cancer

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ABSTRACT: In this study we investigated the role of religious orientation in coping with stresses associated with cancer. A measure of daily coping and the Religious Orientation scale were administered to forty hematology-oncology patients in order to examine frequency of eight coping responses across religious orientations. It was found that proreligious and intrinsic participants used religion significantly more often than nonreligious and extrinsic types to cope with stresses associated with their cancer. We concluded that religious orientation and commitment influence the coping process, and suggest that religious commitment be included in studies of coping with cancer.

Considerable research in recent years has focused on stress and coping.[1] While early approaches considered coping as a trait-like construct, recent acceptance of the transactional theory of Lazarus and Folkman has oriented the study of coping toward situation-specific behaviors and cognitions. Folkman and Lazarus categorized four modes of coping to include direct action, inhibition of action, information search, and intrapsychic, or cognitive, coping.[2] Factor analysis of the Ways of Coping scale, however, revealed two groups of items: problem-focused, which includes strategies such as gathering information, generating possible solutions, and making and following a plan; and emotion-focused responses that involve avoiding, distancing, emphasizing the positive aspects of the situation, seeking emotional social support, and self-blame.[3]

Although a wide variety of coping strategies have been investigated, interestingly only Stone and Neale have included religion as a category of coping.[4] Given the importance that Americans place on religion, with 95% of Americans reporting believing in a God or Universal Spirit and 87% reporting that they pray,[5] it is unfortunate that coping responses such as prayer or religious cognitions have virtually been ignored. What research is available regarding

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the role of religious coping in dealing with stress has been equivocal. On the one hand, data have shown that patients depend on perceived strength of religious beliefs and values in coping with imminent death.[6] Religious individuals indicated positive death-imagery significantly more often than those who rated themselves as less religious,[7] and less fear of death was reported by those who indicated greater religious participation.[8] Praying was also found to be one of three methods most frequently used to cope with chronic pain.[9]

In contrast, other studies have shown that religious orientation did not play a significant role in supporting coping and well-being during serious illness.[10] In an experimental study, a relaxation training group showed significantly more reduction in muscle tension than prayer or control groups, although the prayer group reported feeling more relaxed.[11]

It is important to consider that methodological weaknesses of the above studies include unreliable measurement instruments, lack of operational definitions of terms, and reliance on self-report regarding efficacy of coping responses. Comparing coping effectiveness may also minimize the importance of individual differences in choosing the most personally meaningful coping strategies. A more productive approach may be to understand which coping responses individuals use and the role that religious values play in those choices.

In investigating the role of religious beliefs in coping, it is helpful to examine populations under severe stress. At any given time, 50% of the population has some type of chronic condition that requires medical management,[12] making the total number of individuals affected by chronic disease a substantial one. However, research with patients having chronic illness regarding the role of religious orientation in coping is scarce. Since cancer is one of two major chronic diseases and causes of death in the United States, this population seemed a reasonable one for seeking to understand the role of religious values in coping with life-threatening illness. Therefore, the purpose of this study was to investigate coping responses to various stressors reported by chronically ill cancer patients as a function of religious orientation.

Method

Participants. Forty cancer patients (26 men, 14 women) receiving treatment through the Hematology-Oncology Outpatient Clinic of The University of Iowa Hospitals and Clinics were participants in this investigation. Response rate was 78%. Demographic information demonstrated that patients were representative of the population seen at the clinic. The mean age of participants was 51.1 years (SD = 16.2), and patients ranged in age from 21 to 80 years. The ethnic composition of the sample was primarily white. Of the sample, 75% were married, 10% were widowed, 7.5% were divorced, and 7.5% were single. Table 1 presents patient diagnoses.

TABLE 1

Patient Diagnoses

Acute leukemia	10
Chronic leukemia	4
Lymphoma	22
Myelodysplastic syndrome	2
Multiple myeloma and macroglobulinemia	2
Total	40

Three of the participants had an elementary school education; 23 had a high school education; and 13 had a college degree. Median household annual income was in the $20,000 to $30,000 range, and 50% of the sample were employed either full-time or part-time. Religious affiliations reported by participants were Protestant (68%), Catholic (13%), no religious affiliation (10%), agnostic (7%), and unknown (3%).

Patients were identified as appropriate for this study by their physicians; criteria for participation were an age of 18 or more years and the mental and physical ability to complete the study. After patients were given a brief introductory letter by the receptionist, patients were asked individually to participate by the principal investigator. Patients then completed the study measures in an area adjoining the clinic waiting room or in an examination room.

Measures. In order to measure coping, subjects completed the Measure of Daily Coping.[13] This instrument asked participants to describe "the most bothersome event, issue, or situation you experienced during the past week." Participants then answered yes or no to indicate whether they used each of eight defined coping categories (acceptance, direct action, distraction, letting feelings out, redefinition, relaxation, religion, or social support) in handling the situation. They also provided an example of how they coped in that way in order to verify if the category choice was appropriate. (Three responses were changed from yes to no based on the examples given. In each case, the appropriate category had also been marked with another example provided.)

Coping responses in the original Stone and Neale[14] study were examined, using sixty married couples (N = 120) who were a subsample of residents participating in a longitudinal study of the relation between life stress and health over a period of 21 consecutive days. Inter-rater agreement in sorting the eight coping categories, as measured by kappa, was 0.74. Distraction was used with 27% of the problems, situation redefinition with 25%, direct action with 46%, catharsis with 25%, acceptance with 30%, seeking social support

with 15%, relaxation with 17%, and religion with 6%. Other methods of coping were reported with 7% of the problems.

Religious orientation was measured using Allport's Intrinsic-Extrinsic Religious Orientation Scale.[15] The scale consists of twenty items rated on a four-point scale, and includes eleven extrinsic items (for example, "A primary reason for my interest in religion is that my church is a congenial social activity") and nine intrinsic items (for example, "My religious beliefs are what really lie behind my whole approach to life"). In order to distinguish persons who are "indiscriminately proreligious" (that is, endorse both types of items) from those who are consistently extrinsic or intrinsic, scores are calculated for extrinsic and intrinsic subscales. Donahue's recommended theoretical midpoints of the scales[16] (27 for intrinsic, 33 for extrinsic) were used to classify participants into four groups. Participants were classified as intrinsic if they scored above the intrinsic midpoint and below the extrinsic midpoint. Participants were classified as extrinsic if they scored above the extrinsic midpoint and below the intrinsic midpoint. Participants scoring above the theoretical midpoints on both scales were classified as proreligious, and those scoring below the midpoint on both were classified as nonreligious.

Allport and Ross reported item-to-subscale correlations ranging from 0.18 to 0.58.[17] They found respondents showing an extrinsic religious orientation to be more racially prejudiced than the intrinsically religious respondents; indiscriminately proreligious types were the most prejudiced of all.

Results

In this study, coping categories were used with the following frequencies: acceptance (75%), relaxation (75%), letting feelings out/catharsis (65%), direct action (58%), religion (58%), social support (53%), distraction (38%), and redefinition (13%). These frequencies differ from those reported by Stone and Neale,[18] in that virtually all coping methods were more frequently endorsed.

Further, 50% (N = 20) of the sample was categorized as proreligious, 27.5% (N = 11) as intrinsic, 12.5% (N = 5) as extrinsic, and 10% (N = 4) as nonreligious. Donahue's[19] sample of students at Brigham Young University was 90% intrinsic, and Hood's[20] sample of psychology students was as follows: proreligious (31%), extrinsic (27%), nonreligious (21%), and intrinsic (21%). This study sample, therefore, is somewhat more intrinsic and less nonreligious than Hood's[21] sample of college students.

In order to determine whether coping response frequency differed as a function of religious orientation, a series of chi-square analyses were conducted (see Table 2). Of the eight coping responses, three revealed significantly different distributions across religious orientation: religion ($\chi^2 = 12.54$, df = 3, $p < .01$), direct action ($\chi^2 = 8.65$, df = 3, $p < .05$), and relaxation ($\chi^2 = 7.68$, df = 3, $p < .10$). Results demonstrated that proreligious and intrinsically

TABLE 2

Religious Orientation by Coping Categories

	Pro	Int	Ext	Non	Total (%)
	n = 20	n = 11	n = 5	n = 4	
Acceptance	13	9	4	4	30 (75%)
Relaxation	16	10	3	1	30 (75%)
Let Feelings Out	13	7	3	3	26 (65%)
Direct Action	14	6	3	0	23 (58%)
Religion	14	8	1	0	23 (58%)
Social Support	10	7	3	1	21 (52%)
Distraction	9	4	2	0	15 (38%)
Redefinition	3	1	1	0	5 (12%)

Pro = proreligious, Int = intrinsic, Ext = extrinsic, Non = nonreligious.

TABLE 3

Chi-Square Analysis of Religion Coping Category by Religious Orientation

	Extrinsic	Intrinsic	Nonreligious	Proreligious
Yes	1	8	0	14
No	4	2	4	5

n = 38; 2 participants omitted the question of whether or not they turned to their faith to cope.

oriented participants used religion more often than other types to cope with the stressors associated with their illness. None of the nonreligious participants and only one of the extrinsic participants reported using religion to cope with the stress associated with their illness.

Chi-square analyses also revealed that direct action coping responses significantly differed as a result of religious orientation, in that proreligious and intrinsic participants used direct action to cope significantly more than nonreligious or extrinsic participants ($p < .05$).

Discussion

Our results indicate that individuals of varying religious orientations used differing methods of coping with the stresses associated with their disease. Intrinsic and proreligious individuals used religion-based coping for the

stresses associated with cancer; extrinsic and nonreligious individuals did not. Intrinsic and proreligious participants also used direct action to a significantly greater degree than extrinsic or nonreligious individuals.

These findings lend some support to constructs of extrinsic and intrinsic religious orientations,[22] in that only one participant in the extrinsic group used religion to handle the stressors experienced. These findings also suggest that psychologists should not only focus their attention on traditional coping methods, such as redefinition of the problem or seeking social support, when assisting patients who are coping with cancer. For clients who are religiously oriented, assessment and exploration of how religion is used in coping may be an appropriate direction in therapy.

Limitations of this study include the reliability of the Religious Orientation Scale and the reliance on self-report regarding the use of categories of coping. Because the sample consisted of patients from one hospital clinic, it would be helpful to replicate the findings in other samples. The small sample in multiple cells of the chi-squares resulted in the need for caution regarding significance.

Another issue in interpreting findings is the feasibility of other possible explanations for the findings. It remains unclear whether or not religion is a category distinct from other traditional coping categories, such as redefinition. Although participants appeared to view it as distinct, and behaviors such as prayer appear unique, further research could examine this issue. Another issue of interest for further research is whether or not people change their religious orientations as a result of life-threatening illness. It may be that the somewhat large number of proreligious and intrinsic individuals was a result of the sample responding to their medical conditions. Despite limitations, however, the findings underline the importance of religion as an individual difference variable in coping with the stressors of cancer.

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