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Coping with Breast Cancer: The Roles of Clergy and Faith

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ABSTRACT: This paper describes the experiences of 103 breast cancer patients with home pastors and hospital chaplains. Attention was directed at the activities of clergy, the degree to which religious and nonreligious interactions were satisfying to the women, and how these related to their personal faith orientation. Because of the issues of sexual identity and attractiveness entailed by breast cancer, the role of female clergy was also explored. It is evident that religion is an extremely important resource for the majority of these breast cancer patients, and an intrinsic religious orientation helps one cope with breast cancer.

"When misery is the greatest, God is the closest."[1] Perhaps nowhere is misery greater than when an individual contracts cancer. Potential terminality immediately becomes a salient issue, along with expectations of pain, anguish, and suffering. Physical problems are compounded with a host of psychological difficulties, not the least of which are feelings of isolation, separation, dependency, and helplessness. In such circumstances, religion and prayer have a high likelihood of becoming prime supports for the individual.[2]

Different forms of malignancy create their own unique adjustment problems, and breast cancer poses special difficulties for women. Most commonly, treatment means surgery, and the result can be perceived as mutilation. Early research revealed that mastectomy patients felt that their bodies were deformed and distorted.[3] More recent work discloses coping problems in a variety of areas—work, marriage, and sexual function. As might be expected, unmarried mastectomy patients do not function as well as their married counterparts.[4] As Bard put it, one must appreciate the ramifications of breast cancer, since an "organ of great psychic significance" is removed.[5]

Uniformly, workers in this area point to the need the breast cancer patient has for social support. Jenkins and Pargament note that support from clergy is often not provided cancer patients even though research shows that 64 to 90 percent of cancer patients consider religion to be personally important.[6] In addition, Yates, Chalmer, St. James, Follansbee, and McKegney report that

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among advanced cancer patients feeling close to God, believing prayer is helpful, and attending religious services relate positively to life satisfaction, positive emotional states, and less perceived pain.[7] Unhappily, even in major research programs on breast cancer, religion as a potentially significant variable has often been ignored.[8]

Theory suggests that the beneficial effects of religion may be a function of its roles in providing meaning, maintaining or enhancing one's sense of control, and supporting self-esteem.[9] When cancer strikes, meaning, control, and esteem suffer. The patient must resolve such questions as "why me?" and "why cancer?" Control over one's life is placed in the hands of others; powerlessness ensues, and self-esteem is adversely affected. In these situations, religion can be a constructive alternative, and may be mediated by 1) the personal spiritual orientation of the patient, and 2) religious representatives—the clergy.

In the 1960s, Gordon Allport and his students formulated the concepts of intrinsic and extrinsic religion.[10] Where an intrinsic personal orientation is regarded as a search for truth, a "meaning-endowing framework,"[11] an extrinsic orientation is utilitarian and instrumental. One turns to religion in times of need, while intrinsic religion is an ever-present frame of reference. Research shows that intrinsic religion also relates to constructive thinking and behavior, and aids the person in coping with life.[12]

Spiritual support when cancer strikes is normally provided by clergy.[13] Increasingly, these representatives of institutional religion are being trained in clinical pastoral skills and crisis management, yet what they actually do with the patient and the latter's responses to the clergy are still largely unexamined. Breast cancer, because of its sexual significance, implications about attractiveness, and female identity, could impose unique constraints on the pastor-patient interaction. Both male clergy and female patients may be less willing to confront these pertinent issues than might be true if the cleric is female. The purpose of the present research was to gain such information and relate it to the form of the patient's faith.

Given the foregoing, certain hypotheses are suggested.

1. Because of both their pastoral role and familiarity with the patient, home pastors will use religious activities more than will hospital chaplains. In like manner, home pastors will be perceived as discussing the patient's family more and as being more understanding than will hospital chaplains. In contrast, the latter, owing to their training, will be viewed as engaging more in counseling.
2. Satisfaction with home pastors and hospital chaplains will be positively related to using religious activities during the visits. Perceived reluctance to discuss the breast cancer and its importance for sexual identity and attractiveness will be viewed negatively by the women.
3. Because of the implications of breast cancer for female identity and at-

tractiveness, patients who encounter female pastors and hospital chaplains will be particularly pleased with such clerics. In general, a preference will be expressed for female clergy.

4. To the extent the women are intrinsically oriented, they will be favorably disposed toward clergy visits to the home and hospital, religious activities on the part of the clergy, and will be satisfied with clerical efforts. In contrast, extrinsic tendencies will relate to nonreligious clerical actions and oppose religious ones.

Method

Sample. The participants were 103 women volunteers who were recruited through the American Cancer Society (ACS). All were mastectomy patients currently associated with the ACS Reach-to-Recovery support group for women with breast cancer. Their average age was 53.4 years (S.D. = 11.05). Most of the women (81.3%) had some college education; 14 percent were high school graduates, while four percent attended vocational school after high school.

Of the 103 respondents, 71.8 percent indicated a specific church affiliation; and of these, 70 percent were Protestant, 14 percent were Catholic, six percent were Jewish, and eight percent indicated "other." Nineteen religious bodies were represented, with the largest groups being Methodist (51%), Lutheran (11%), and Baptist (10%). Half of the women (49%) indicated that they attended church weekly prior to their illness. Only 9.7 percent reported no church attendance. Eighty-eight percent stated that religion was important to very important to them, while 12 percent considered religion unimportant. No significant change was evident from pre-illness time to the present in religious attitudes and involvement.

Measures. A two-part questionnaire was employed. One part used the Allport-Ross version of the intrinsic-extrinsic scale with a six-point Likert format in which responses ranged from strongly disagree to strongly agree.[14] The reliabilities for these instruments were: intrinsic faith, $r_{tt} = .85$; extrinsic faith, $r_{tt} = .60$.

Part two of the questionnaire contained 99 items that asked about religious perspectives and activities, clergy-patient interactions, self-perceptions of emotions, coping with the cancer, and a variety of demographic characteristics (age, education, and so on). Concern here is with the interaction of the patients with both home pastors and hospital chaplains. Questions were asked about patient requests for clerical contact, the number of such interactions both in the home and the hospital, and what activities took place during the meetings. On the basis of previous work, attention was directed at prayer, Bible or other religious reading, counseling, talking about the church, family,

the future, irrelevancies, and the feeling that the pastor or chaplain understood the patient.[15] Open-ended items permitted consideration of other possible activities, as well as what was satisfying or displeasing to the patient. Similar information was also sought on involvement with female clergy.

Results and discussion

Contacts with the clergy. Table 1 provides the basic information on contacts between clergy and the breast cancer patients. Twenty-eight (27.2%) of the women were visited in their home by their own minister, and 58 (56.3%) saw their pastor when hospitalized. Thirty-eight (36.9%) of the women saw a hospital chaplain, but only 31 chaplains were perceived as spending much time with the women. This may have been due to rejection by the women, or a failure on the part of some chaplains to follow up an initial introductory visit.

The women were generally well pleased with the visits of both home pastors and the hospital chaplains. In only one instance was dissatisfaction expressed with a minister's home visit, and only twice with similar visits to the hospital. Displeasure was expressed for only three of the visits by hospital chaplains.

Clergy activities. Hypothesis one gains some support in relation to religious activities. As expected, home pastors actually pray with the patient more than do hospital chaplains. The former, for obvious reasons, also tend to discuss church affairs. Hospital chaplains are seen as speaking about irrelevant matters significantly more than home clergy. This may relate to the chaplain's being a stranger who needs time to determine what is relevant to each patient. In general, however, from the patient's viewpoint, home pastors and hospital chaplains are quite similar in their pastoral actions.

Satisfaction with clergy. As noted, the women were very favorably disposed toward both their home pastors and hospital chaplains. The reasons for this positive attitude only partially support hypothesis two. Understandably, if the patients were satisfied with the visits of their own minister to the home, they were also pleased with the hospital visits. The same holds true for the few times hospital chaplains visited the home. This implies a general feeling of being positive or negative toward the home pastor, a view also bolstered by the high correlations between satisfaction and the feeling of being understood by the clergy. Being understood, however, is independent of all of the other activities by which the home minister relates to the patient. Apparently, there is a quality in the relationship that counts, and this may or may not involve any of the expected pastoral actions of the home clergy. The same appears to be true for the hospital chaplain; however, there is one exception. In patient-chaplain interactions, a rather strong association is found between

TABLE 1

Data on Patient-Clergy Contacts, Actions, and Evaluations

Visits by Clergy (Percentages of Total Sample).

Home pastor			
In Home	22.3 % (23)[1]	Requested visits	5.0 % (5)
In hospital	52.4 (58)	" "	6.8 (7)
Mean number of visits	2.6		
Hospital Chaplain			
In home	9.5 % (8)	Requested visits	9.5 % (8)
In hospital	39.3 (38)	" "	2.4 (2)
Mean number of visits	1.9		

Satisfaction with home and hospital visits by clergy (percentages of patients visited)[2]

Home pastor:	home	hospital	*Chaplain:*	home	hospital
Pleased	92.7	96.2		98.0	97.1
Displeased	7.2	3.8		2.0	2.9

Actions of clergy during visits (percentages)

	Home pastor (N = 58)	*Hospital Chaplain* (N = 31)	*t-test*
Offer to pray for you	58.6	71.0	1.159
Offer to pray with you	50.0	35.5	1.317
Actually pray with you	53.4	29.0	2.216*
Did religious readings (Bible, etc.)	13.8	13.2	1.589
Counseled with you	15.5	12.9	.332
Talked irrelevancies	15.5	38.7	2.468*
Understood feelings, concerns	53.4	45.2	.741
Talked about church affairs	17.2	0.0	2.464*
Talked about your family	43.1	29.0	1.376
Talked about your future	17.2	19.4	.259
Seemed in a hurry to leave	3.6	9.1	1.090
Had difficulty identifying hospital chaplain		8.3	
Visited by female clergy	16.8 (N = 17)		
If not, would have preferred female cleric,	20.0		
Degree of satisfaction with female cleric: Pleased		76.5	
Displeased		23.5	

[1]Sample sizes (N's) given in ().
[2]Since the sample sizes are given above, only percentages of the samples who saw clergy are given in the remainder of the table.
*Indicates significance at .05 level.

the feeling of being understood and considering the patient's future ($r = .54$, $p < .01$). Still, satisfaction with the chaplain is independent of such discussions even if they imply understanding.

Hypothesis two relates differentially to the home pastor and hospital chaplain (see Table 2). Where these expectations gain no support for home clergy, the opposite is sometimes true for the chaplains. Not only is satisfaction independent of religious activities for the home pastor, but in the instance of reading from the Bible or other religious material, such behavior is viewed negatively. Could such actions be perceived as preparing the woman for death? Whatever the reason, this is not what these women desire. In contrast, offers by the hospital chaplain to pray for and/or with the patient are greeted positively. The feeling that the chaplain is counseling is also favorably received, as are discussions about the patient and her family. Apparently women with breast cancer respond favorably to a much greater range of activies than just those with religious connotations.

The role of the female pastor. Hypothesis three is not supported (see Table 2). Seventeen of the women related to female pastors and chaplains, but only 20 percent of the entire sample would have preferred a female. The age of the patient is clearly a factor here, as age correlated $-.42$ ($p < .01$) with preference for a female cleric. It appears the older women feel more comfortable with the traditional male churchman. This may explain why approximately three-quarters (76.5%) of those who saw a female cleric were pleased with this contact when, as Table 1 indicates, general satisfaction with clergy ranged from 92 to 98 percent.

Sexual identity was of some concern to approximately half the sample (52.4%), and of great import to 20.6 percent of the women; 76.5 percent were also anxious about the effect of the cancer on personal attractiveness. In other words, three-quarters of the women were indeed anxious about these issues. Still, only three of the women discussed these matters with either male or female clergy. A contributing factor might have been the sensitivity of such concerns, as 12 of the women saw their home pastor as reluctant to deal with the breast cancer; seven of the women felt similar reticence on the part of the hospital chaplains. These small numbers do not, however, explain the discrepancy between the expressed concern and lack of communication about female identity and attractiveness. Whether the cleric was male or female, the issue rarely came up.

The role of personal faith. Table 3 reveals that hypothesis four is partially supported. For the home pastor, frequency of visits to the home, hospital, and, therefore, obviously the total number of visits correlate positively and significantly with intrinsic faith. In addition, actually praying with the patient also associates meaningfully with an intrinsic orientation. Persons with this outlook are disinclined to see their pastors as in a hurry to leave, and since such

TABLE 2

Correlations Between Forms of Personal Faith and Clergy Variables

Religious orientation	*Home pastor* Satisfaction Home	Hospital	*Hospital Chaplain* Satisfaction Hospital[2]
Clergy variables			
No. visits to home	.00	.26*[1]	—
No. visits to hospital	−.02	−.05	−.19
Total visits	.51***	.12	−.17
Home visits requested	.11	.04	—
Hospital visits requested	.25	.11	.30*
Satisfaction with home visits	—	.70***	.81**
Offer to pray for patient	.05	−.17	.37**
Offer to pray with patient	.02	−.09	.39**
Actually pray with patient	.19	.13	.22
Read Bible, etc.	.05	−.28**	−.07
Counsels patient	.09	−.15	.33*
Talks irrelevancies	.13	−.16	−.18
Understands patient	.50***	.30**	.41**
Talks about church affairs	.36**	.19	—
Talks about patient's family	.05	.07	.34*
Talks about patient's future	.13	−.08	−.14
Perceived in hurry to leave	—	−.08	−.14
Discuss sexual/attractive issues	.12	−.06	.23
Reluctance to discuss br. cancer	−.28	−.45***	−.22
Reluctance to discuss woman's role	−.30	.00	.00
Reluctance to discuss male relations	.11	−.16	.00

[1]The coefficients are based on different size samples due to variations in patient response.
[2]In seven instances, hospital chaplains visited homes; however, because of this small sample, home variables are not considered.
*Indicates significance at .10 level; **at .05 level; ***at .01 level.

individuals are often quite constructive in viewpoint, working with them may be rewarding to the ministers.

Relative to the hospital chaplain, the total number of visits also affiliates with an intrinsic perspective, while not expected is a positive tie between extrinsic religion and the number of visits chaplains make in the hospital. One might infer that this is expressing a utilitarian need for religious support. Extrinsity further associates with an offer to pray with the patient.

TABLE 3

Correlations Between Forms of Personal Faith and Clergy Variables

Religious orientation	*Home Pastor* Intrinsic	Extrinsic	*Hospital Chaplain* Intrinsic	Extrinsic
Clergy variables				
No. visits to home	.22**	.05[1]	—	—
No. visits to hospital	.22**	−.04	−.13	.32***
Total visits	.32**	−.21	.40**	−.18
Home visits requested	.07	.11	—	—
Hospital visits requested	.06	.08	.03	.07
Satisfaction with home visits	.27	−.40**	.51	.38
Satisfaction with hospital visits	.19	−.29*	.16	.24
Offer to pray for patient	.04	.00	−.28	.32
Offer to pray with patient	.10	.16	−.13	.39*
Actually pray with patient	.49***	−.19	−.01	.31
Read Bible, etc.	.21	−.16	−.27	−.25
Counsels patient	.06	−.19	−.19	−.27
Talks irrelevancies	−.16	.30**	−.01	−.04
Understands patient	.21	.04	.07	−.12
Talks about church affairs	.02	−.19	—	—
Talks about patient's family	.12	.10	−.28	.15
Talks about patient's future	.19	−.22	−.12	−.20
Perceived in hurry to leave	−.32**	.15	.03	.18

[1]The coefficients are based on different size samples due to variations in patient response.
*Indicates significance at .10 level; **at .05 level; ***at .01 level.

These findings with religious orientation are sparse, but, in the main, meaningful.

There is much evidence that faith can be a great comfort when one is threatened with cancer. In the present sample, 85.4 percent of the women reported that religion helped them cope with their illness. We also saw that well over 90 percent of our sample were pleased with the ministrations of their home pastors and the hospital chaplains. Despite these crucial observations, the hypotheses advanced here were only partially supported. A number of factors may account for and qualify these findings.

The need for supportive phenomenological analysis. Clearly, crisis situations are complex, and the full import of breast cancer on a woman's psychological state may not be capable of exacting evaluation by single, simple,

objective items. Low or non-statistically significant results could result from the unreliability of individual items, even though they may be excellent markers. Scales would have been desirable; hence, many more questions would have had to be constructed, and this is an avenue that might be fruitful in future research.

A strong case can be made for phenomenological analysis, and our request for open-ended written responses resulted in many indications of the deep significance that faith had in this extremely stressful situation. In addition, the volunteered remarks help clarify the objective findings.

The meaning of clergy visits. The general satisfaction with clergy was manifested primarily in the pleasure conferred by the presence of either the home pastor or hospital chaplain. Remarks such as, "Just came to visit, a show of caring," "concerned about me," and "Simply, he was there—cared" were most common. These were encapsulated in the summary statement of one woman, "Just to feel that someone cares," and indeed this was a fundamental need of these women that was often met by a visit from her minister or the chaplain. In one instance, a minister and his wife drove over 100 miles to see the patient; the beneficial psychological effect of such an occurrence cannot be calculated. The words "care" and "caring" were repeatedly employed, and were evidently a core concept for many of the women. Clergy visits as a sign "that someone cares" acquired additional significance, for a number of the women expressed a touch of pleased guilt that their busy home pastor took the time to visit and help.

An interesting problem was how long a visit should be. Some women complained of a visit's brevity; others, that it was too long. Clergy obviously need to be sensitive to cues provided by patients regarding visit length.

The roles of prayer and ritual. Caring was repeatedly associated with prayer. Not only personal praying with a cleric, but the prayers of others were much appreciated. One woman was very pleased that her church 1600 miles away held prayer sessions for her; another appreciated "praying for me during a mass."

The "power of prayer" is not to be taken lightly. It represents a form of control that identifies the individual with ultimate power sources.[16] Prayer has also been treated as an active cognitive coping strategy that relates positively both to problem-focused and successful emotion-focused coping.[17]

Of secondary significance to most of the women were formal religious activities. One appreciated a "mini-service," and "receiving communion." The opposite was also true. A patient objected to "pushing generalized formal religion," or being "pushy about attending mass more." The consolation of ritual should not, however, be underplayed; neither ought it be considered a necessity without regard for the patient's feelings. Ceremony may be functional in that participation in ritual can imply ingratiation and identification with

church and God.[18] Some of the women also distinguished sharply between institutionalized religion and individual faith. A sensitive pastor will attempt to test the situation in order to determine what "works."

The importance of God relationships. It is quite understandable that, in these stressful circumstances, God relationships might become crucial. One woman stated that she knew "no matter what happens, God is with me. I am never alone. He will give me the strength I need." Another averred that "we knew God was not punishing us with cancer because we had been bad. . . . I believed that it was in the Lord's hands and that the outcome would be the right one for me and my family." For this woman, there was little if any ambiguity; meaning was present. Though it is not objectively clear what this meaning might be, another woman gained similar courage through meaning. She claimed, "I had no idea God could answer so many of my questions." Control was in the hands of a benevolent God. Both of these patients were thus able to maintain their self-esteem in the face of the cancer threat. These points were frequently stated: God was indeed a source of strength; God offered answers; and, in one form or another, it was repeatedly asserted that "My God does NOT cause cancer." One woman attributed the cancer to the devil.

In a parallel manner, others became the tools or agents of God. A patient spoke "of the wonders of God's works and the talents he gave doctors, ministers and lay people to help someone when they really hurt."

Sources of dissatisfaction. This was not a time to be judgmental and callous, yet some clerics were certainly unfeeling. One woman wanted her minister to pray for a miracle, but he refused. Another told the patient that she was dying, and he would pray for her soul to go to heaven. In a similar vein, a pastor told the patient that she was a sinner and unsaved.

A more passive but equally distressing situation was reported by two women. Though active in their churches, no minister visited them. As one put it, "I felt abandoned by my church—but not necessarily by God. . . . I cannot bring myself to return." In this day of pastoral sophistication, it is hard to believe that such insensibility still exists. Obviously, the actual experience of patients can be very instructive and should become a more significant part of clinical pastoral education.

Similar signs of unhappiness were frequently noted, but these occurrences were obviously not strong enough to counter the positive feelings most of the women experienced toward the clergy.

The issues of identity and attractiveness. The largely negative objective results with respect to female clergy could be a function of the relative importance of the various patient concerns. As noted under direct questioning, sexual identity and attractiveness were sources of apprehension to one-half to

three-quarters of the women, yet only one woman spontaneously referred to "society's emphasis on 'breast' size as a sign of femininity." Female identity and attractiveness took a back seat to what was often termed "life and death." This theme was repeated with words like "dying," "life expectancy," "reoccurrence," "spreading." The simple statement, "I didn't want to die" encapsulated the core concern of these women.

A secondary theme, but also one that was continually reiterated, dealt with the abandonment of children, husband, and other relations. A number of times, faith entered the picture. One woman's main concern was "to become closer to God"; another associated her family's protection with her relationship to God. A third patient feared that she would die before she "completed my spiritual growth during this life time."

Still, there were indications that female sexual identity and attractiveness were important issues. One woman who did not discuss this with a cleric did talk to a male nurse who was comforting. Another dealt with attractiveness with her female friends; in a similar manner, a receptive male friend was a good sounding board regarding attractiveness.

Perceived reluctance on the part of clergy to consider these matters was a source of distress to more than a few of the women. Though one stated that "sexuality needs to be discussed," most commonly noted was an aversion on the part of the clergy to address breast cancer while talking about cancer per se. Somewhat caustically, one patient, in referring to her interaction with a pastor, remarked that "He *even* mentioned breast cancer in conversation." Without question, the women were sensitive to the topic. About half felt comfortable with the matter, while others offered explanations as to why it was not treated. In one instance, the patient considered herself the problem. She noted, "I wanted to appear strong and in control. I didn't want to talk about it (guess I thought it would go away)." The issue was indeed delicate, and lack of discussion was attributed to the shyness of a pastor, not knowing a cleric well enough, the "awkwardness" of the problem, and the belief that clergy "are not certain a woman wants to discuss it with them." Despite expectations that a female pastor might be in a better position to bring up these concerns, we had no indication that the female pastor had any advantage over her male counterpart. It was, however, abundantly evident that the patients themselves were quite unlikely to broach the topic.

Religion's help in dealing with breast cancer. No question elicited more of a response from the women than, "Was your religion any help in dealing with your breast cancer?" In only two instances was religion viewed as irrelevant. Many of the women wrote at length about God in their lives, the importance of prayer, and having a faith that endowed one with courage. A theme that was repeatedly echoed was that God was an ever-present supportive healer and companion in whom the patient could confide. If a lesson can be learned from these remarks, it is that religion is an extremely important resource for

almost all breast cancer patients, particularly, as in the present study, with upper middle class, rather well-educated women. There is also little doubt from the findings on the role of personal faith that an intrinsic spiritual orientation is particularly meaningful in perceiving religion as an aid in dealing with the cancer. The latter correlates .70 ($p < .01$) with an intrinsic faith, while an extrinsic orientation is independent of help from religion ($r = -.05$).

Summary

This research examined the experiences of breast cancer patients with home pastors and hospital chaplains. Attention was directed at the pastoral activities of the clergy, and their effectiveness with these women. Because of the psychological import of breast cancer, the role of female clerics and the issues of female sexual identity and attractiveness were also studied. Sources of satisfaction and dissatisfaction with clergy were identified. Since the nature of the personal faith of the women might be a significant mediating variable, the place of intrinsic and extrinsic spiritual orientations was explored and found to be an important factor in the relationship of religion and coping behavior.

It is evident that religion is an extremely important resource for the great majority of the women in the present sample. This confirms other research on cancer patients. Visits by home pastors and hospital chaplains were greatly appreciated. Satisfaction with clergy centered about the idea of being understood. Since this did not relate to any of the activities assessed here, more research needs to be undertaken to know what this really means. Though sexual identity and attractiveness are a source of concern to most of the women, such issues are rarely discussed with clergy. Perceived reluctance to deal with these matters is a source of patient dissatisfaction with pastors. Female clerics did not demonstrate any advantages over their male peers in dealing with breast cancer patients, and were actually preferred less than male pastors. Finally, there are indications that an intrinsic religious orientation does help one cope with breast cancer.

Inconsistency in the objective findings suggests that research of this nature be buttressed by the gathering of subjective data that can be phenomenologically examined. Such information is likely to be of much utility in clinical pastoral education. These programs need to consider in greater depth the actions of clergy who deal with breast cancer patients. In conclusion, it is felt that the recipients of pastoral care are really a largely unexplored teaching resource, not only for this condition, but for illness in general.

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