Religious and Nonreligious Coping among Cancer Patients

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Summary

A pilot study was conducted at the outpatient clinic of the department of medical oncology of Radboud University Nijmegen Medical Centre. The goal was to draw up an inventory of religious and nonreligious coping strategies of patients with a life threatening disease such as cancer. Current research focuses on various forms of coping. An often neglected coping strategy is religious coping. Research in this field so far was conducted mostly in the USA. When it comes to religion and worldview the Netherlands differs from the USA in important respects. In this article we explore religious coping in the context of the Dutch society.

1   Introduction

Cancer is the second largest cause of death in the Netherlands, after coronary heart disease. Cancer treatment is demanding and gives no guarantees of full recovery. These factors induce high levels of pressure on cancer patients and their family and friends. They have to learn to live with the threat of imminent death and the insecurity that accompanies cancer. For religious people their

faith can play an important role in the adjustment process. If they are hospitalised, spiritual carers are available to assist them in this process. However, frequently patients are treated at outpatient clinics, where spiritual care is rarely available. To respond to some extent to the absence of spiritual care in the specific context of an outpatient clinic spiritual support could be offered in the form of short-term pastoral counselling. To examine the possibility of this solution to the problem of spiritual care more insight is required into cancer patients' coping and the role of religion in this process.

To this end we did a pilot study at the outpatient clinic of the department of medical oncology of Radboud University Nijmegen's Medical Centre as part of an evaluation of an educational programme of the Faculty of Theology at the Radboud University Nijmegen. The pilot study was meant to draw up an inventory of religious and nonreligious coping strategies of people with a life threatening disease such as cancer. Current research focuses on various forms of coping. An often neglected coping strategy is religious coping. Research in this field so far has been performed mainly in the USA (Pargament, 2001). The Netherlands differs from the USA in important respects when it comes to religion and worldview. In this article we explore religious coping in the Dutch society.

2   Dealing with Cancer: Coping

The term 'coping' derives from Freudian psychoanalysis. Coping was seen as a defence mechanism. Thanks to cognitive psychology this view of coping has changed radically. Nowadays coping is understood to be an active form of information processing, in which the coper is not guided by stable personal characteristics but by interaction with his/her environment (Pieper & Van Uden, 2003). There are many definitions of coping. Oosterwijk (2004, 25) combines several of these into a single definition that captures the essence of coping: "Coping is the cognitive behavioural effort that a person makes to deal with the demands of others, the situation or themselves whereby he presumes that the demands will test his capabilities or perhaps even exceed them. The aim of this effort is to control, end, reduce or tolerate the stressful situation."

Cancer is a threatening, stressful situation that causes psychosocial strain. The coping process of cancer patients aims to reduce the strain of threatening situations and to improve the chances of recovery or at least stabilisation. Cancer patients have to learn to deal with the negative effects of their disease and try to restore their self-image and emotional balance (Oosterwijk, 2004). There are different theories to explain this mechanism. The *just-world theory* assumes that people believe in a just world, in which everyone receives what one deserves and deserves what one receives. This assumption not only renders

events understandable and manageable, but also imbues them with value and meaning (Lerner, 1971). Thus, if someone is affected by a life threatening disease such as cancer, one tries to find meaning in the suffering, for example by looking at a positive outcome like personal growth or greater appreciation of life (Ten Kroode, 1990; Oosterwijk, 2004). According to the *social comparison theory* people in threatening situations tend to compare themselves with others by way of upward or downward social comparison. Upward social comparison compares one's situation with that of someone who is better off than oneself; downward comparison entails comparison with someone who is worse off. By identifying with someone who is better off and distancing oneself from someone who is worse off one can give maximum meaning to an event, gain control of the situation and restore one's identity (Taylor, 1983). According to the *attribution theory* people have a need to understand the world around them. They search for explanations of events and try to discover the connection between events. These attributions help them to gain and keep control of a situation (Ten Kroode, 1990; Heider, 1958; Kelley & Michela, 1980). Hence attributions play an important role in people's experience of control, which relates positively to the degree of adjustment (Janoff-Bulman & Wortman, 1977; Taylor, Lichtmann & Wood, 1984). Cancer patients have very little control over their illness. Attributions can reduce their sense of lack of control. Besides a sense of control, attributions also give meaning to a situation.

In the next section we take a closer look at the coping theory of Lazarus and Folkman. These authors have made an important contribution to the distinction between different phases of the coping process and different forms of coping.

3   Coping according to Lazarus and Folkman

Lazarus and Folkman (1984) define coping as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person". They developed a four- step model. Coping starts with an initial judgement of the situation (primary appraisal). If the situation is beneficial or irrelevant, nothing will be done. If the situation is dangerous or if something is at stake, the person has to decide how to deal with it. He/she will look at the available options, the means at his/her disposal and the expected future effects (secondary appraisal). After this cognitive consideration the person attempts to deal with the situation by means of available coping strategies. Finally, the person evaluates the course of the coping process (reappraisal). He/she assesses the effect of the coping process and makes adjustments if necessary. If adjustments are necessary, the whole process will be repeated.

Lazarus and Folkman distinguish between two different coping strategies. First one can try to tackle the problem directly, which Lazarus and Folkman call problem-focused coping. This coping strategy seeks to lessen the problematic situation. Secondly, one can try to influence the meaning of the problem and its emotional effects, which they call emotion-focused coping. This strategy seeks to restore emotional balance and self-image, for example through upward or downward social comparison (Lazarus & Folkman, 1984). Depending on the specific situation, a coping strategy can lead to improvement or deterioration of emotional well-being. In a situation that can be changed problem-focused coping leads to reduced stress and greater emotional well-being, whereas emotion-focused coping will most likely result in increased stress. In a situation that cannot be changed emotion-focused coping is more adequate, whereas problem-focused coping can be counterproductive (Folkman & Lazarus, 1988).

According to Manuel et al. (in De Ridder, 1996) patients do not restrict themselves to one coping strategy. It does not matter so much which coping strategy is applied, but rather how suitable it is in the given situation. An active approach, for example, is better for gaining information, while distancing is more suitable for dealing with strong emotional reactions (Osowiecki & Compas, 1998). When choosing a strategy to cope with a serious disease three criteria are crucial. The first is whether or not the disease is life threatening. According to Feifel, Strack and Nagy, the emotion-focused approach is generally used in the case of life threatening diseases (De Ridder, 1996). The second criterion is the possibility of control. If it is not possible to exert control over the progression and effects of the disease, emotion-focused coping is more likely to be used (Felton & Revenson, 1984). The third criterion is the predictability of the disease progression. The possibility of predicting the progression of the illness goes hand in hand with the degree of insecurity. A study by Heim et al. showed that when predictability of disease progression is low, insecurity is greater and one resorts to emotion-focused coping sooner (in De Ridder, 1996). Cancer is a life threatening disease, the progression of the illness is difficult to predict and there are few possibilities of control, so one can hypothesise that cancer patients will primarily use emotion-focused coping (Oosterwijk, 2004).

4   Measuring Nonreligious Coping

In previous studies of the use of different coping styles, problem- and emotion-focused coping styles are often subdivided into diverse strategies. A widely used instrument is the Ways of Coping Scale by Folkman en Lazarus (1986). It comprises the following eight scales: confrontive coping, distancing, self-

control, seeking social support, accepting responsibility, escape-avoidance, planful problem solving and positive reappraisal. However, on theoretical grounds, Carver, Scheier and Weintraub (1989) have argued that this instrument does not cover the full range of possible coping reactions. For this reason they developed COPE, which consists of fourteen coping strategies: active coping; planning; suppression of competing activities; restraint coping; seeking social support for instrumental reasons; seeking social support for emotional reasons; positive reinterpretation and growth; acceptance; turning to religion; focus on and venting of emotions; denial; behavioural disengagement; mental disengagement; and alcohol/drug disengagement. In both studies the difference between active problem-focused coping and more passive emotion-focused coping is emphasised.

Recently Oosterwijk (2004) conducted a study of cognitive coping strategies of breast cancer patients in the Netherlands. She describes the following strategies:

1. Doomsday thinking: 'Essentially I have already said goodbye.'
2. Evading: 'I don't want to know.'
3. Addressing oneself: 'Come on, have faith.'
4. Finding a cause: 'It is probably hereditary.'
5. Adopting a positive angle: 'It made me stronger.'
6. Resignation: 'That's the way it is.'
7. Protest: 'I am just angry.'
8. Trivialise: 'There were only a few small metastases.'
9. Rationalising guilt: 'I have always lived a healthy life.'
10. Downward comparison: 'Compared to her I'm well off'
11. Upward comparison: 'It seemed to go well for her too'

Thus, a fair number of strategies have been identified as representative of non-religious coping with cancer.

5   Religious Coping

For a long time little attention was paid to religious coping. Over the past ten years, however, this has changed because of growing evidence that religion can influence psychological and physical health (Koenig, McCullough, & Larson, 2001; Plante & Sherman, 2001; Seybold & Hill, 2001). Pargament was the first to study religious coping systematically. In his *The psychology of religion and coping* (1997, 32, 90) he defines religion as "the search for significance in ways related to the sacred" and coping as "the search for significance in times of stress". Religion is closely related to meaning and can therefore greatly

enhance the coping process. Religion helps people to look for the intention and meaning of a stressful situation (Folkman & Moskowitz, 2004) and offers answers when factual knowledge is inadequate. In this section we look into the role that religion can play in the coping of cancer patients. Following Pargament we distinguish between a functional and a relational approach to religious coping and between positive and negative coping.

Functional approach to Religious Coping

According to Pargament (1997) religious coping seeks to maximise meaning giving. In a functional approach to religious coping one assumes that this can be achieved in two ways: by holding on to important existing (religious) values (conservation of significance) or by letting go of these values and changing them (transformation of significance).

In the case of *conservation of significance* one tries to hold on to the familiar. A person can try to protect her existing religious values by means of known resources (preservation). He/she will draw a sharp line between his/her own life and the outside world by building a wall to protect important religious values from external threats. Another form of 'preservation' is to seek spiritual or religious support from God or the religious community. If familiar resources fail to protect existing values, one can maximise meaning by trying new resources (reconstruction). One can reinterpret the situation in a way that leaves the existing values intact (religious reframing). Another possibility is to look for another God or religious community that is better able to preserve existing values (religious switching) (Pargament, 1997).

However, some events are so drastic that holding on to existing values becomes impossible and *transformation of significance* is unavoidable. Changing and letting go of these values is a difficult, intensive process. That is why people first try to find new values with the aid of familiar resources (re-evaluation). Value transformations can be achieved by means of rites of passage such as baptism or marriage. The transition from existing to new values cannot always be made with the aid of familiar resources. In that case one has to pursue these new values by harnessing new resources ('re-creation'). An example of such radical change is conversion. Religious forgiveness is another form of 're-creation', in which one distances oneself from all anger, pain and sorrow. This, too, requires radical change (Pargament, 1997).

Relational approach to Religious Coping

Another way to approach religious coping is to look at the relationship between God and the person in question. Pargament et al. (1988) distinguish between

three styles in their Three Styles of Religious Coping Scale, each involving a different relation between a person and God. The first style is *self-directing*. The person takes responsibility for finding a solution, because God has endowed humans with the means and skills to determine their own lives. The second style is *deferring*. The person leaves the responsibility for finding a solution to God and passively awaits the outcome. The third style is *collaborative*. God and the person share the responsibility for finding a solution. It is a give-and-take relationship on equal terms. Wong-McDonald (2000) adds a fourth style: *surrender*. This style differs from deferring, in that one does not passively wait for a solution but actively and consciously hands the problem to God.

Positive and Negative Religious Coping

Usually religion is assumed to influence spiritual and physical health positively (Kaye & Raghavan, 2002; Kirkpatrick, Shillito, & Kellas, 1999; Pargament, 1997; Pargament et al., 1994; Pieper & Van Uden, 2000), but this is not always the case. Therefore Pargament et al. (1998) differentiate between positive and negative religious coping strategies as well. Positive strategies lead to positive effects and negative strategies to negative effects.

Positive religious coping strategies express a feeling of spiritual relationship with the transcendent, a stable connection with God, the realisation that life has deeper meaning and a sense of spiritual bonding with others. Examples of positive religious coping are positive revaluation, collaborative religious coping, active surrender to God, searching spiritual support, religious purification, religious forgiveness and seeking support from clergy or members of the church community. These coping strategies are also used to give meaning to drastic events, to regain control, find peace and accomplish a reorientation by harnessing new sources of meaning to replace old beliefs and values (Pargament, Koenig & Perez, 2000). The use of these (positive) strategies is associated with improved adjustment.

Negative religious coping strategies express a less stable relationship with God, a gloomy worldview and a religious struggle in the search for reason. The category of negative religious coping comprises fear of divine punishment, fear of demons, reappraisal of God's power, and spiritual doubts. These types of religious coping are often associated with poor adjustment. Two types of religious coping — adopting a passive attitude (deferring) and developing one's own initiatives (self-directing) — have both positive and negative results (Pargament et al., 1998; Pargament et al., 2000; Harrison et al., 2001).

Several studies have explored the relation between religious coping and psychological adjustment to stress. The results differ (Van Heck & Van Uden,

2005). A meta-analysis affords insight into this diversity. Ano and Vasconcelles (2005) selected 49 studies of the relation between different types of religious coping and psychological adjustment to stress. Their quantitative meta-analysis confirms that positive and negative types of religious coping correlate with positive and negative types of psychological adjustment. This implies that one cannot make deductions about whether religion is beneficial or detrimental without first critically considering the contents of the religious practices.

6   Religious Coping with Cancer

Being confronted with a life threatening disease such as cancer raises questions concerning one's own identity, control possibilities, social relations and meaning (Cole & Pargament, 1999; Johnson & Spilka, in Jenkins & Pargament, 1995). Religion can help by offering alternatives (Johnson & Spilka, in Jenkins & Pargament, 1995). Religion offers frameworks of meaning for reinterpreting the situation. The problem remains, but the perception of the problem changes. Thus, the person can view the situation as a way of getting closer to God (Pargament, 1997). Religious interpretations of the disease can help cancer patients to transform the situation into a positive experience and enable spiritual growth (Jenkins & Pargament, 1995; Gall, 2000). Another way is to let go of uncontrollable situations (Cole & Pargament, 1999) and partially or fully surrender one's responsibility to a transcendent power (Naim & Merluzzi, 2003), because it becomes easier to accept human limitations. Acceptance can lead to a sense of peace and security (Cole & Pargament, 1999) when the person no longer feels he has to face it alone (Nairn & Merluzzi, 2003).

For the chronically ill religion can give life meaning (Woods & Ironson, 1999) and in this way acts as a buffer against fear and depression (Bickel et al., 1998). Many cancer patients consider religion a source of consolation and power (Jenkins & Pargament, 1995). Religion helps them to deal with the insecurity by finding meaning for the disease (Taylor, Lichtman & Wood, 1984). Religion helps cancer patients to place the disease in their life story (Cole & Pargament, 1999) by offering them accompaniment, support and hope (Pargament et al., 1988).

Thus religion can be a vital asset for the coping of religious cancer patients. The more religion is integrated with the personal orientation system, the more important its role in the coping process (Pargament, 1997). For nonreligious people religion plays little or no role in their orientation system, hence they will most probably not make use of religious coping strategies. Sometimes,

however, they are influenced by transformation of significance, which makes the religious perspective meaningful for them.

7 Measuring Religious Coping

Religious coping has only been studied scientifically in recent years. Previously research was limited to adding a few items to a (coping) questionnaire. Consequently there are few comprehensive measurements available except the RCOPE of Pargament, Koenig and Perez (2000). The RCOPE distinguishes between five main coping domains connected to five religious functions: finding meaning, gaining control, gaining comfort and closeness to God, gaining intimacy with others, and life transformation.

(1) The domain, 'finding meaning', comprises the following coping styles:
   – positive religious revaluation
   – God's plan; learning the deeper meaning of life
   – negative religious revaluation: divine punishment
   – blaming the devil
   – limiting God's power: human freedom.
(2) The domain, 'gaining control', comprises the following coping styles:
   – collaboration with God
   – active and passive surrender to God
   – asking for a miracle or divine intervention.
(3) The domain, 'gaining comfort and closeness to God', comprises the following coping styles:
   – seeking God's love and care
   – seeking forgiveness
   – feeling forsaken by God
   – stricter adherence to God's rules.
(4) The domain, 'gaining intimacy with others', comprises the following coping styles:
   – support by chaplains
   – support by like-minded believers
   – praying for self and others
   – discontent about support of chaplains and like-minded believers.
(5) The domain, 'life transformation', comprises the following coping styles:
   – asking God for a new purpose in life
   – conversion
   – forgiving others.

There are both an extensive and an abridged version of RCOPE. So far there have been a few studies that used the abridged RCOPE instrument (e.g. Mytko & Knight, 1999). The extensive version — the one we are discussing — is actually too long to be used in a questionnaire. Thus the RCOPE, at least the extended version, remains a theoretical instrument, of which on empirical grounds we cannot say whether it covers the entire range of religious coping.

Alma, Pieper and Van Uden (2003) come to the conclusion that Pargament's problem-solving styles in the domain, 'gaining control' (Pargament et al., 1988), are very difficult to implement in the Netherlands because of the underlying image of an active, personal God. In the Netherlands many people have a non-personal image of God. (Van der Ven, 1998) Therefore, the currently available religious coping questionnaires may fail to identify relevant religious coping strategies in these people (Van Laarhoven et al., 2009). Hence Van Uden, Pieper and Alma (2004) developed the receptiveness scale as an alternative. This scale takes into account that people are not trying to find an immediate solution to the problem. They allow for a receptive attitude, implying trust that a solution will come.

8   Research among Cancer Patients at Radboud University Nijmegen's Medical Centre

The preceding sections have shown that learning to live with cancer can be difficult and painful. Religion can be a major asset for coping in that religious cancer patients often find it a source of support, consolation and power. Certainly coping can also take place without the help of religion, but religion can make it easier by offering something to hold on to (e.g. religious explanation of diseases). Accordingly we formulated the following research question: "What religious and nonreligious coping strategies can be identified for people with a life threatening disease such as cancer?"

Since there are currently no valid questionnaires for measuring the religious coping of cancer patients, we decided to use qualitative methods. In the course of evaluating an educational pilot project patients of Radboud University Nijmegen's Medical Centre were interviewed.

8.1   *Data Collection*

The participants in the project in the period October 2003 to January 2004 were patients of the department of medical oncology at Radboud University Nijmegen Medical Centre. In the selection the patients' condition was taken

into account. All the patients were approached by doctors and nurses of the department and were given an oral explanation and written information about the project. In this way a list was compiled of patients who were willing to cooperate. Two psychology students contacted the patients to discuss the research procedure again and to answer questions. After obtaining the patients' final consent the information was passed on to a pastoral counsellor, who got in touch with the patients. A total of 54 patients were approached, of whom twenty agreed to participate in the project.

Of these twenty patients five patients dropped out in the course of the project due to deterioration of their condition. The group who completed the project consisted of five men and ten women, fourteen of whom were receiving palliative treatment[1] and one was on curative treatment.[2] Their ages varied between 41 and 70 years, with an average age of 59. For practical reasons we decided to randomly select seven patients for further analysis.

Three contacts were planned. The first was a semi-structured interview by the pastor, in which the anamnesis was recorded, including the following information: illness, past and present coping, worldview and future expectations. The second contact was a free conversation, in which the pastor based his intervention on themes from the first conversation; this intervention was agreed upon beforehand and discussed in an educational setting. The third contact was again a semi-structured interview by the psychology students, in which the pastoral contacts were evaluated with the patients; specific questions were asked about the possible meaning of the spiritual care for their own view of life and religious coping. A questionnaire on dealing with serious disease was also given to the patients to explore their (religious) coping styles.

8.2   *Measuring Instruments*

In order to answer the research question a category system was developed during the analysis of the data on religious and nonreligious coping strategies from the first interview with the patients. Initially the religious coping strategies were categorised with the aid of the RCOPE of Pargament, Koenig and Perez (2000) described above. Nonreligious coping was also initially categorised by means of existing measuring instruments. The coping strategies identified by Folkman and Lazarus (1986) in the Ways of Coping Scale, and by Carver, Schreier and Weintraub (1989) in COPE were initially used. These were amplified with the coping strategies defined by Oosterwijk (2004). Using

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[1] Palliative treatment aims at postponing and alleviating complaints for as long as possible. This treatment is chosen when a cure is no longer possible.

[2] Curative treatment is aimed at achieving a cure.

these instruments, the first draft category system was developed. It consisted of two main categories: religious and nonreligious coping. These were then divided into subcategories. The procedure used for the further development of the initial category system comprised two steps. In the first step all the project staff (the authors of this article) independently studied the actual conversation of one case. They marked and labelled quotations that they considered to be religious or nonreligious coping and also indicated the type of coping. In the second step the case was discussed by all the project staff. Sometimes a quotation was coded differently by different staff members. In such cases the final choice of a category was decided upon by way of discussion. Sometimes quotations were marked if they could not be labelled according to the category schemes. If after discussion it was decided that it was a relevant coping style, it was added to the category system. During the processing of the collected interview data the initial category system was modified many times; existing coping styles were replaced and new ones were added. Previously processed interview data was reassessed, using the revised version of the category system. Following this procedure all seven selected cases were analysed with the aid of the revised category system.

8.3   *Results*

The research question was: what religious and nonreligious coping strategies can be identified among people with a life threatening disease such as cancer?

Table 1 gives an overview of the final category model developed in the course of the pilot study. Coping strategies that were added on the basis of the analysis of the interviews are italicised.

Table 1: Religious and nonreligious coping strategies

I   Religious coping strategies

1. Meaning giving
    a. Positive religious revaluation: God's plan or learning the deeper meaning of life
    b. Negative religious revaluation: divine punishment
    c. Attribute to the devil
    d. Limitation of God's power
    e. *Religious hope*
    f. *Religious conviction (existence of the hereafter)*
    g. *Theodicy (reflection on the relation between suffering and God)*

2. Relation to God
    a. Collaborating with God
    b. Active and passive surrender to God
    c. Asking for a miracle and divine intervention
    d. Being forsaken by God
    e. *Anger/rebellion against God*

Table 1 (*cont.*)

3. Divine consolation and proximity
    a. *Seeking and experiencing God's love and power*
    b. *Concentrating on the religious domain*
    c. Seeking forgiveness
    d. *Divine consolation*
    e. Stricter adherence to religious rules
    f. *Religious practices (performing religious acts)*

4. Intimacy with like-minded believers
    a. Support of spiritual care givers
    b. Support by like-minded believers
    c. Praying for others
    d. *Others pray for you*
    e. Dissatisfaction with support of spiritual care givers and like-minded believers

5. Transformation
    a. Asking God for a new goal in life
    b. Conversion
    c. Forgiveness

II   Nonreligious coping strategies

1. Problem confrontation
    a. *Identification of the problem*
    b. Active approach to the problem
    c. Taking responsibility
    d. Venting emotions
    e. Making plans
    f. *(Near) future orientation/hope*
    g. Postponing distracting activities
    h. Searching for a cause

2. Putting the problem in perspective
    a. Seeking distraction
    b. Distancing
    c. Postponing action
    d. Downward social comparison (own situation is better)
    e. *Putting into perspective (humour)*
    f. *Helping others*
    g. *Meditating*
    h. *Reading/music/art*

3. Support
    a. Instrumental social support
    b. Emotional social support
    c. *Professional support*
    d. Social support

Table 1 (*cont.*)

4. Positive reinterpretation
    a. Positive revaluation
    b. *Enhancement of own powers*
    c. Adopting a positive angle
    d. Acceptance
    e. Resignation
    f. *Letting go*
    g. Self-control/self-direction

5. Denial and avoidance of the problem
    a. Denial
    b. Protesting/rebelling against
    c. Avoidance
    d. Trivialising
    e. Doomsday thinking, upward social comparison (own situation is worse)
    f. Giving up
    g. Alcohol/drug use
    h. *Postponement of problem confrontation*

The final category model explained above was used to analyse each case. Tables 2 and 3 show the distribution of the different coping strategies among the patients. We also give the total scores per category per patient (based on data from the first interview). The names of the patients are fictional. To understand the tables properly it should be noted that this is a qualitative project with a small group of patients, hence it is not possible to base general conclusions on these numbers.

Table 2: Religious coping

	Beelen	Hansen	Hoff	Laverne	Nooteboom	Wevers	Witjes	Total
Meaning								
pos. religious revaluation	1	0	2	0	0	2	4	**9**
neg. religious revaluation	0	0	0	0	0	0	0	**0**
attribute to the devil	0	0	0	0	0	0	0	**0**
limitation of God's power	0	0	0	0	0	0	0	**0**
religious hope	2	0	0	0	0	0	0	**2**
religious conviction	0	0	0	1	0	1	4	**6**
Theodicy	0	1	0	0	0	1	1	**3**
Total	**3**	**1**	**2**	**1**	**0**	**4**	**9**	**20**

Table 2 (*cont.*)

	Beelen	Hansen	Hoff	Laverne	Nooteboom	Wevers	Witjes	Total
Relation to God								
collaborating with God	0	0	0	0	0	0	0	**0**
surrender to God	4	1	0	0	0	3	0	**8**
ask for a miracle	0	2	0	0	0	0	0	**2**
forsaken by God	0	0	1	0	0	0	0	**1**
protest/anger	0	1	0	0	0	0	0	**1**
Total	**4**	**4**	**1**	**0**	**0**	**3**	**0**	**12**
Divine consolation								
God's power	1	1	1	3	0	2	3	**11**
aiming at religious domain	0	0	0	0	0	1	1	**2**
seeking forgiveness	0	0	0	0	0	0	0	**0**
consolation	0	0	0	0	0	0	0	**0**
abide by religious rules	0	0	0	0	0	0	0	**0**
religious practices	2	6	1	9	0	5	2	**25**
Total	**3**	**7**	**2**	**12**	**0**	**8**	**6**	**38**
Intimacy with like-minded believers								
support spiritual care givers	3	1	0	0	0	0	0	**4**
support like-minded believers	3	0	0	0	0	0	1	**4**
praying for others	0	0	0	0	0	0	0	**0**
others praying for you	1	0	0	0	0	2	1	**4**
dissatisfaction with support	0	0	0	0	0	0	0	**0**
Total	**7**	**1**	**0**	**0**	**0**	**2**	**2**	**12**
Transformation								
new life goal	0	0	0	0	0	0	0	**0**
conversion	0	0	0	0	0	0	0	**0**
forgiveness	0	0	0	0	0	0	0	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cumulative	*17*	*13*	*5*	*13*	*0*	*17*	*17*	*82*

Table 3: Nonreligious coping

	Beelen	Hansen	Hoff	Laverne	Nooteboom	Wevers	Witjes	Total
Problem confrontation								
identification	7	2	2	3	3	1	0	**18**
active approach	0	3	1	1	1	1	0	**7**
taking responsibility	0	0	2	0	2	1	0	**5**
expressing emotions	0	1	1	3	3	1	0	**9**
making plans	0	1	1	0	2	0	0	**4**
future orientation	2	1	6	0	2	1	2	**14**
stopping distracting activities	0	0	0	0	0	0	0	**0**
seeking causes	0	0	0	0	0	1	0	**1**
Total	**9**	**8**	**13**	**7**	**13**	**6**	**2**	**58**
Putting the problem in perspective								
seeking distraction	0	3	1	0	6	2	0	**12**
distancing	1	2	1	0	4	1	0	**9**
postponement	0	0	0	1	0	0	0	**1**
downward social comparison	0	7	1	0	3	2	0	**13**
relativisation	0	2	0	0	2	0	1	**5**
helping others	0	3	0	1	0	0	1	**5**
meditating	0	0	0	0	0	1	0	**1**
reading, music	0	0	0	0	5	0	0	**5**
Total	**1**	**17**	**3**	**2**	**20**	**6**	**2**	**51**
Support								
instrumental social support	0	0	0	0	0	0	0	**0**
emotional social support	1	1	3	2	4	3	3	**17**
professional support	1	0	0	0	2	0	0	**3**
social support	0	0	0	1	0	1	0	**2**
Total	**2**	**1**	**3**	**3**	**6**	**4**	**3**	**22**
Positive reinterpretation								
positive revaluation	0	2	1	3	7	1	2	**16**
enhancement of own powers	0	0	1	1	0	1	0	**3**
adopting a positive angle	0	0	0	2	4	0	0	**6**
acceptance	0	1	0	0	3	1	0	**5**
resignation	0	1	0	0	1	1	0	**3**

Table 3 (*cont.*)

	Beelen	Hansen	Hoff	Laverne	Nooteboom	Wevers	Witjes	Total
letting go	0	0	1	0	0	2	2	**5**
self-control	0	0	1	0	1	0	1	**3**
Total	**0**	**4**	**4**	**6**	**16**	**6**	**5**	**41**
Problem denial and avoidance								
denial	0	0	0	2	0	0	0	**2**
protesting	1	1	4	2	1	0	0	**9**
avoidance	0	0	0	1	0	0	0	**1**
trivialising	0	0	0	0	0	0	0	**0**
Doomsday thinking	0	0	1	0	0	0	0	**1**
giving up	0	0	1	0	0	0	0	**1**
alcohol and drug use	0	0	0	0	0	0	0	**0**
postpone problem confrontation	0	2	0	0	0	0	0	**2**
Total	**1**	**3**	**6**	**5**	**1**	**0**	**0**	**16**
Cumulative	*13*	*33*	*29*	*23*	*56*	*22*	*12*	*188*

The results in tables 2 and 3 tell us the following. The use of religious coping strategies was scored 82 times and that of nonreligious coping strategies 188 times. This means that of all the coping strategies identified among the respondents almost a third are religious (RC) and two thirds are nonreligious (NRC).

The patients who used the RC categories most frequently (Beelen, Wevers and Witjes — 17 times each) scored less frequently on the NRC categories (Beelen 13 times, Wevers 22 times, and Witjes 12 times). There is only one respondent who made absolutely no use of religious coping: Mr Nooteboom. This respondent reported nonreligious coping styles most frequently (56 times). He used mainly putting the problem in perspective (20 times).

The religious subcategories were scored as follows: seeking and finding consolation and proximity to God, 38 times; seeking meaning, 20 times; relation to God, 12 times; intimacy with like-minded believers, 12 times; and life transformation, 0 times. Thus in the category 'religious coping' the subcategory 'consolation and proximity to God' scored highest, namely 38 times. In this subcategory 'religious practices' was by far the most frequently observed strategy (25 times). It entailed participating in religious rituals such as attending mass, visiting holy places and reading religious literature. The strategy 'seeking and experiencing God's love and power' also had a high score (11 times). In the other categories there are only two strategies with noteworthy scores:

positive religious revaluation (9 times) and active/passive surrender to God (8 times). The subcategory 'transformation' remains empty in all seven cases.

Religious coping is aimed at handling emotion not solving the problem. This is evident in the low score on the subcategory 'relation to God' that aims at solving the problem (e.g. by asking for a miracle). Negative religious coping (e.g. 'attribute to the devil', 'anger/protest against God' and 'dissatisfaction with pastors and like-minded believers') hardly features.

The nonreligious subcategories scored as follows: problem confrontation, 58 times; putting the problem in perspective, 51 times; positive reinterpretation, 41 times; social and professional support, 22 times; and problem denial, 16 times. In the category 'nonreligious coping' the subcategory 'problem confrontation' scored highest (58 times), followed by 'putting the problem in perspective' (51 times). 'Problem denial' scored lowest (16 times). Hence there was clearly a realistic approach without use of defence mechanisms like repression.

Again we stress that this is a qualitative project with a small group of patients. It is therefore not possible to base general conclusions on these numbers. One can merely formulate intra-group comparisons and use these to generate hypotheses to be tested in further research.

9   Conclusions

In the course of evaluating the education project we looked for religious and nonreligious coping strategies used by cancer patients. Even though the use of nonreligious coping styles scored highest in terms of absolute numbers, religious coping appeared to be an important addition to the coping process of these cancer patients. Religion can offer support to cancer patients in their coping process. Hence attention to this dimension of coping is of great importance.

On the basis of existing instruments we developed a more complete category system. The analysis of the material shows that the coping strategies that we added are relevant: they are frequently applied by the patients that took part in our pilot study. We also found that in the case of religious coping two strategies were used most by the patients we researched: seeking God's power, and religious practices (participating in rituals). In this context Kwilecki's (2004) criticism of present-day coping research is relevant. She says that current coping research is too cognitive in its approach and disregards special religious experiences and (magical) ritual acts as possibly relevant coping strategies.

A religious coping strategy that was never used by the patients in this study was transformation of faith. This accords with Pargament's view that people primarily use their own existing faith as a coping strategy. Only in extreme circumstances (when the existing faith really offers no solution) people may follow the difficult route of changing their religious values.

Positive religious coping is more common than negative religious coping. This means that one can expect the well-being of the patients studied to be positively influenced. Previous studies of psychiatric patients in the Netherlands already indicate this (Pieper & Van Uden, 2005).

Religious coping focuses particularly on emotions and meaning giving. In cases where the problem cannot be solved this is a good strategy. An important option here is positive religious revaluation in the form of experiencing the disease as an opportunity for learning on the deeper meaning of life.

In conclusion, spiritual care in the form of support of this religious coping process in an outpatient clinical setting should be advocated. Considering the small scale of this pilot study further research is warranted.

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