Original Article

Images of God in Relation to Coping Strategies of Palliative Cancer Patients

Hanneke W.M. van Laarhoven, MD, PhD, Johannes Schilderman, PhD, Kris C. Vissers, MD, PhD, FIPP, Constans A.H.H.V.M. Verhagen, MD, PhD, and Judith Prins, PhD

Department of Medical Oncology (H.W.M.v.L., C.A.H.H.V.M.V.), Expert Centre of Palliative Care (K.C.V., C.A.H.H.V.M.V.), Department of Anesthesiology, Pain and Palliative Medicine, and Department of Medical Psychology (J.P.), Radboud University Nijmegen Medical Centre, Nijmegen; Comprehensive Cancer Centre East (C.A.H.H.V.M.V.), Nijmegen; and Department of Empirical Theology (H.W.M.v.L., J.S.), Faculty of Theology, Radboud University Nijmegen, Nijmegen, The Netherlands

Abstract

Context. Religious coping is important for end-of-life treatment preferences, advance care planning, adjustment to stress, and quality of life. The currently available religious coping instruments draw on a religious and spiritual background that presupposes a very specific image of God, namely God as someone who personally interacts with people. However, according to empirical research, people may have various images of God that may or may not exist simultaneously. It is unknown whether one's belief in a specific image of God is related to the way one copes with a life-threatening disease.

Objectives. To examine the relation between adherence to a personal, a nonpersonal, and/or an unknowable image of God and coping strategies in a group of Dutch palliative cancer patients who were no longer receiving antitumor treatments.

Methods. In total, 68 palliative care patients completed and returned the questionnaires on Images of God and the COPE-Easy.

Results. In the regression analysis, a nonpersonal image of God was a significant positive predictor for the coping strategies seeking advice and information ($\beta = 0.339$, $P < 0.01$), seeking moral support ($\beta = 0.262$, $P < 0.05$), and denial ($\beta = 0.26$, $P < 0.05$), and a negative predictor for the coping strategy humor ($\beta = -0.483$, $P < 0.01$). A personal image of God was a significant positive predictor for the coping strategy turning to religion ($\beta = 0.608$, $P < 0.01$). Age was the most important sociodemographic predictor for coping and had negative predictive value for seeking advice and information ($\beta = -0.268$, $P < 0.05$) and seeking moral support ($\beta = -0.247$, $P < 0.05$).

Conclusion. A nonpersonal image of God is a more relevant predictor for different coping strategies in Dutch palliative cancer patients than a personal

Address correspondence to: Hanneke W.M. van Laarhoven, MD, PhD, Department of Medical Oncology, Radboud University Nijmegen Medical Center, P.O. Box 9101, 6500 HB Nijmegen, The Netherlands. E-mail: h.vanlaarhoven@onco.umcn.nl

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or an unknowable image of God. J Pain Symptom Manage 2010;40:495–501.

Key Words
Religion, images of God, coping, palliative care

Introduction

Religion and spirituality are increasingly recognized as important domains to include in the care for patients with a life-threatening illness.[1,2] According to reports in the United States and Canada, 50%–90% of cancer patients view religion or spirituality as personally important.[3–5] Religion and spirituality can offer a source of comfort, meaning, control, and personal growth to patients who are confronted with a life-threatening disease.[6] In a recent multicenter study, 78.8% of the patients with advanced cancer ($n = 272$) reported that religion helped them to cope to at least a moderate extent.[7] When asked about sources of support, religiousness is spontaneously mentioned by 26.1% of cancer patients.[8]

The way patients draw on their religion or spirituality to understand and adapt to a specific situation of crisis is referred to as religious coping.[9] Several specific religious coping scales have been developed to overcome the limitations of general coping scales, which include only a few items on religious coping and fail to capture the broad range of cognitions and practices related to religious coping.[10–13] For example, the Ways of Religious Coping Scale measures the degree and kind of cognitions and behaviors people use to cope with stress.[14] The Brief Measure of Religious Coping (RCOPE) examines specific clusters and patterns of items that are divided into positive (adaptive) or negative (maladaptive) coping strategies.[6] The Religious Coping Activities Scale measures the specific content of various potentially positive or negative coping strategies, such as good deeds, religious support, and religious avoidance.[15] In the Religious Problem Solving Scale, three religious ways of maintaining a sense of agency and control in coping are distinguished: first, collaborative religious coping, in which God is a partner who shares responsibility with the individual for problem solving; second, deferring coping, in which the individual delegates responsibility to God while passively waiting for the outcome; and last, self-directed coping, in which the individual assumes that God has given him the skills and resources to solve the problem himself.[16] The attempt to influence the will of God by praying for positive outcomes or pleading for a miracle may be added to this scale as a fourth way of coping.[15]

Using these instruments, it has been shown that religious coping is important for end-of-life treatment preferences, advance care planning, adjustment to stress, and quality of life.[3,5,7,17,18] It should be noted that the currently available religious coping instruments draw on a religious and spiritual background that presupposes a very specific image of God, namely God as someone who personally interacts with people.[19] However, according to empirical research, people may have various images of God that may or may not exist simultaneously. For instance, in The Netherlands, many people have a nonpersonal image of God, regarding God as "something higher," or an unknowable image of God, which implies that God surpasses all our powers of imagination.[20,21] It is unknown whether one's belief in a specific image of God is related to the way one understands and adapts to a situation of crisis. In this study, we examined the relation between adherence to a personal, a nonpersonal, and an unknowable image of God and coping strategies in a group of Dutch palliative cancer patients who were no longer receiving antitumor treatments and were facing death.

Methods

Study Sample

As part of a larger project on religion and palliative care, a self-administered questionnaire was given out to palliative cancer patients from the Departments of Internal Medicine and Medical Oncology, and the Palliative Care Unit of one university and two general hospitals, two hospices, and a regional consultation

service for palliative care in The Netherlands. The study was approved by the institutional medical ethics board, and all participating patients gave written informed consent.

The inclusion criteria were as follows: patients with advanced solid tumors, not receiving antitumor therapies anymore, and recovered from acute treatment toxicities. Exclusion criteria were inability to read Dutch or extreme morbidity precluding filling out a questionnaire.

Measurement Instruments

Sociodemographic data were collected from all participants. Disease information was provided by the treating physician. Patients completed the Images of God Scale, a Dutch 14-item instrument, which has been used, among others, in a large survey ($n = 1008$) on sociocultural developments in The Netherlands.[20–22] It assesses adherence to a personal image of God (e.g., "God knows and understands me"), a nonpersonal image of God (e.g., "There is Something that unifies man and world in their very roots"), and an unknowable image of God (e.g., "God [Someone or Something] surpasses our powers of imagination"). The internal consistency (Cronbach's α) of the scales of Images of God was 0.98 for a personal image of God, 0.93 for a nonpersonal image of God, and 0.81 for an unknowable image of God. Images of God were scored from 1, totally disagree, to 5, fully agree. Coping was measured by the COPE-Easy abbreviated version, which is a validated instrument in Dutch measuring 14 different coping strategies.[10,23] The internal consistency of the subscales of the COPE-Easy ranged from 0.63 to 0.98. Coping strategies were scored from 1, not applicable, to 4, very much applicable.

Statistical Analysis

Associations between adherence to a personal, a nonpersonal, or an unknowable image of God (low vs. high) and patient characteristics were analyzed using χ^2 and *t*-tests when appropriate. Agreement with an image of God was computed "low" if a patient scored <3.5 and "high" if a patient scored ≥ 3.5 (on a scale from 1 to 5), ensuring that in the "high" category only patients were included who were really convinced of a particular image of God.

Associations between images of God and coping strategies were first analyzed by Pearson's correlation analysis. Significant associations were taken up in a stepwise regression model including relevant sociodemographic factors. In stepwise regression, each variable is entered in sequence and its value assessed. If adding the variable contributes to the model, then it is retained, but all other variables in the model are then retested to see if they are still contributing to the success of the model. If a variable is no longer contributing significantly, it is removed. This method ensures that the final model is the simplest equation with the best predictive power. Relevant factors were considered to be sociodemographic patient characteristics significantly associated with both an image of God and any of the coping strategies. Patient age and sex, religious affiliation, church attendance, and religious salience (importance of religion for daily life) were identified as such factors. In case more than one image of God correlated with the same coping strategy, all images of God were taken up in that regression model. All statistical analyses were performed with SPSS (version 16.0.1; SPSS, Inc., Chicago, IL). Statistical inferences were based on two-sided tests, with $P < 0.05$ considered to be statistically significant.

Results

Patient Characteristics

Between July 2003 and December 2005, questionnaires were administered to 113 consecutive eligible patients. Forty patients did not return the questionnaire. The most common reason for nonparticipation was nonspecific ("I just don't feel like filling out the papers anymore"), and 20% died before they could return the questionnaires. Five patients did not fully complete the Images of God Scale and were excluded from the analysis. Therefore, data from 68 patients were available for analysis. Participants and nonparticipants did not significantly differ by age or sex.

Colorectal cancer (22%), lung cancer (13%), and breast cancer (13%) were the most common tumor types. Most patients were Catholic (53%) or Protestant (13%); 6% had another religious affiliation, and 28% reported no

religious affiliation. Baseline characteristics of the sample by level of agreement with a personal, a nonpersonal, or an unknowable image of God are presented in Table 1. Older patients and female patients scored higher on a personal image of God than younger and male patients. Although there was a significant association between agreement with the images of God and religious affiliation, church attendance, and religious salience, they could not be equated: between 43% and 50% of the patients who scored low on the images of God still reported a religious affiliation. Of the patients who scored high on the images of God only, up to 30% visited church regularly (monthly or more), and 35%–51% of these patients explicitly stated that religion was relevant in their daily lives.

Images of God and Coping

Tables 2 and 3 show correlation and regression analyses of the relationship between images of God and coping strategies. A nonpersonal image of God was significantly correlated to five coping strategies, whereas a personal image of God was correlated to one coping strategy, and an unknowable image of God was correlated with none of the coping strategies. In the regression analysis, a nonpersonal image of God remained a significant positive predictor for the coping strategies seeking advice and information, seeking moral support, and denial, and a negative predictor for the coping strategy humor. A personal image of God was a significant positive predictor for the coping strategy turning to religion. Age was the most important sociodemographic predictor for coping and had negative predictive value for seeking advice and information and seeking moral support.

Discussion

This study shows for the first time that—compared with a personal or an unknowable image of God—a nonpersonal image of God is the most relevant predictor for coping in a group of Dutch palliative cancer patients. In contrast, adherence to an apophatic image of God was unrelated to any of the coping strategies. This suggests that the belief that God surpasses all our powers of imagination implies that God is

Table 1

Population Characteristics by Level of Agreement with a Personal, a Nonpersonal, or an Unknowable Image of God

	Agreement with a Personal Image of God					Agreement with a Nonpersonal Image of God					Agreement with an Unknowable Image of God				
	Low		High			Low		High			Low		High		
Characteristic	Total No. of Patients	Mean (SD)	Total No. of Patients	Mean (SD)	*P*	Total No. of Patients	Mean (SD)	Total No. of Patients	Mean (SD)	*P*	Total No. of Patients	Mean (SD)	Total No. of Patients	Mean (SD)	*P*
Age	31	58 (8)	37	66 (10)	0.000	21	61 (9)	47	63 (11)	0.415	26	61 (10)	42	64 (10)	0.222
		No. (%)		No. (%)			No. (%)		No. (%)			No. (%)		No. (%)	
Male sex	31	20 (65)	37	14 (38)	0.028	21	12 (57)	47	22 (47)	0.431	26	14 (54)	42	20 (48)	0.618
Living with a partner	30	22 (73)	37	22 (60)	0.234	20	12 (60)	47	32 (68)	0.524	25	14 (56)	42	30 (71)	0.198
Education: ≥vocational training	31	16 (50)	36	16 (50)	0.558	21	11 (34)	46	21 (66)	0.609	26	10 (39)	41	22 (54)	0.225
Employment	31	11 (36)	37	8 (22)	0.205	21	7 (33)	47	12 (26)	0.508	26	7 (27)	42	12 (29)	0.883
Religious affiliation	31	14 (45)	37	32 (87)	0.000	21	9 (43)	47	37 (79)	0.003	26	13 (50)	42	33 (79)	0.014
Regular church attendance	31	0 (0)	37	11 (30)	0.001	21	1 (5)	47	10 (21)	0.088	26	1 (4)	42	10 (24)	0.030
Religious salience	31	1 (3)	35	18 (51)	0.000	21	3 (14)	45	16 (36)	0.075	26	5 (19)	40	14 (35.0)	0.167

Agreement with an image of God was computed "low" if a patient scored <3.5 and "high" if a patient scored ≥3.5 (on a scale from 1 to 5).
SD = standard deviation.

Table 2
Correlations Between Images of God and Coping Strategies

	Personal God	Nonpersonal God	Unknowable God
Active handling of the circumstances			
r	−0.046	0.239	−0.078
Sig.	0.715	0.053	0.531
Planning how to deal with the situation			
r	−0.181	0.007	−0.137
Sig.	0.142	0.954	0.270
Giving priority to the situation			
r	−0.027	−0.050	−0.046
Sig.	0.832	0.691	0.714
Waiting until an appropriate moment to act presents itself			
r	0.154	0.235	0.152
Sig.	0.216	0.057	0.222
Reappreciate the situation			
r	0.142	0.153	0.109
Sig.	0.256	0.221	0.385
Seeking advice and information			
r	0.231	0.327[a]	0.085
Sig.	0.060	0.007	0.493
Seeking moral support			
r	0.088	0.247[b]	−0.029
Sig.	0.481	0.046	0.816
Venting of emotions			
r	0.022	0.120	−0.117
Sig.	0.862	0.339	0.348
Denial			
r	0.022	0.264[b]	−0.007
Sig.	0.857	0.031	0.955
Giving up of one's goals			
r	−0.097	−0.051	−0.166
Sig.	0.439	0.681	0.184
Seeking distraction			
r	0.006	−0.153	−0.229
Sig.	0.964	0.220	0.064
Acceptance			
r	0.162	−0.103	−0.087
Sig.	0.194	0.411	0.487
Turning to religion			
r	0.709[a]	0.435[a]	0.147
Sig.	0.000	0.000	0.235
Humor			
r	−0.011	−0.375[a]	−0.227
Sig.	0.932	0.002	0.069

Pearson's correlation coefficient *r* is given.
Sig. = significance.
[a] $P < 0.01$.
[b] $P < 0.05$.

more distant from daily life, and patients who adhere an apophatic image of God may be more reliant on other resources. This hypothesis is supported by a previous study in prostate cancer survivors, which showed that men who had a more distant image of God reported a greater sense of internal control and mastery over their illness.[4]

Clearly, it matters which image of God patients adhere to: a nonpersonal image of God cannot simply be equated with a personal or an unknowable image of God. This is especially important because religious coping questionnaires often presuppose a personal image of God and, therefore, may fail to identify coping strategies that are related to a nonpersonal image of God. Thus, new religious coping questionnaires that take into account different images of God, as measured by the Images of God Scale, are urgently needed. Of note, most studies on religious coping of cancer patients have been conducted in the United States.[13] However, it has been shown that religious beliefs and practices can largely differ among countries,[24] and the relevance of a personal, a nonpersonal, or an unknowable image of God for coping strategies may differ accordingly. At present, it is unclear how prevalent religious coping is in various countries throughout the world.

In studies using the currently available religious coping scales, it has been shown that religious coping is associated with patient preferences for extensive measures to prolong life and receipt of intensive life-prolonging medical care near death.[5,7] In our study, the association between a nonpersonal image of God and the coping strategy denial could be an indication of patient preference for life-prolonging medical care. However, the association between a nonpersonal image of God and the coping strategies seeking advice, information, and moral support suggests that patients adhering to a nonpersonal image of God may be open to the advice of their treating physicians to turn to a more palliative course of care.[25]

Limitations of the Study

The results of our study cannot be generalized beyond our study population because we are not only limited by the national context of the study (viz. The Netherlands) but also by the fact that religious minorities from The Netherlands were not included in the study (all but two participants were Catholic or Protestant). Also, our patient group was relatively small, and we have tested multiple hypotheses with the possibility of reporting spurious associations. Ideally, because of our relatively small study sample, our results should be validated

Table 3
Stepwise Regression Analysis of Images of God on Coping Strategies

Dependent Variable	Model	Independent Variables	Standardized Coefficients Beta	Sig.	R^2 Change	R^2	Adjusted R^2
Seeking advice and information	1	Nonpersonal God	0.330	0.007	0.109[a]	0.109[a]	0.095
	2	Nonpersonal God	0.339	0.004	0.071[b]	0.180[a]	0.154
		Age	−0.268	0.023			
Seeking moral support	1	Nonpersonal God	0.255	0.042	0.065[b]	0.065[b]	0.050
	2	Nonpersonal God	0.262	0.032	0.061[b]	0.126[b]	0.097
		Age	−0.247	0.044			
Denial	1	Nonpersonal God	0.261	0.036	0.068[b]	0.068[b]	0.053
Turning to religion	1	Personal God	0.701	0.000	0.491[a]	0.491[a]	0.483
	2	Personal God	0.608	0.000	0.054[a]	0.545[a]	0.545
		Church attendance	0.251	0.008			
Humor	1	Nonpersonal God	−0.373	0.000	0.139[a]	0.139[a]	0.125
	2	Nonpersonal God	−0.483	0.000	0.059[b]	0.199[a]	0.172
		Religious salience	0.267	0.039			

Stepwise regression analysis was performed of images of God on relevant coping strategies as determined from the correlation analysis (see *Methods*). Per coping strategy, all significant models are shown with the independent variables, which were entered successively.
Sig. = significant.
[a] $P < 0.01$.
[b] $P < 0.05$.

in a second independent set of data to allow for definite conclusions. Finally, from this study, a causal relationship between images of God and coping strategies cannot be established because, for example, there may have been an unknown third variable influencing both of these variables. Nevertheless, this study does offer an explorative insight into the relation between images of God and coping.

Conclusion

A nonpersonal image of God is the most relevant predictor for coping in a group of Dutch palliative cancer patients. When discussing prognosis and treatment options, clinicians should be attentive to the different coping methods that patients may use and carefully examine the role of their religious beliefs and values. To assist clinicians in discussing these issues with patients at the end of life, practical training programs should become widely available.[26,27]

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