November 2004 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Fitchett, G., Murphy, P. E., Kim, J., Gibbons, J. L., Cameron, J. R. and Davis, J. A. "**Religious struggle: prevalence, correlates and mental health risks in diabetic, congestive heart failure, and oncology patients**." *International Journal of Psychiatry in Medicine* 34, no. 2 (2004): 179-196.

SUMMARY AND COMMENT: This article should resonate with many chaplains who are familiar with how patients can experience religious struggle in the midst of illness. Much of the literature about the connections between religion and health in the last decade has looked at religion (or, more broadly, spirituality) as a helpful resource for patients during illness and treatment, but of course religion can also be a source of inner conflict and stress. As the authors of the this month's article note in their opening paragraph:

> As people attempt to integrate the reality of grave illness or other adverse life events into their pre-existing religious beliefs, they may ask, "God, why did you let this happen to me?" For some this period of religious struggle may be brief, but for others it can be quite protracted. It may lead to growth and transformation for some people and to distress and despair for others. [p. 180]

And so, the authors set out in this tripartite study to explore the incidence and level of religious struggle and its demographic and religious correlates in groups of diabetic outpatients (n = 71), congestive heart failure outpatients (n = 70) and oncology inpatients (n = 97). A secondary purpose was to look at possible connections between religious struggle and emotional distress.

This is an exceptionally well-written article: a combination of eloquent straightforwardness and scientific detail. Most should find it a pleasure to read, and though there is statistical language at points that may be difficult for non-researchers, the results are clearly presented and quite interesting. Also, each of the measures employed is given a paragraph description, which may offer good suggestions for other researchers. The measure for religious struggle was the negative religious coping subscale of the Brief RCOPE, and the seven items of that subscale are conveniently listed in a summary table [see p. 187]. There are a total of five tables, containing a great deal of statistical information.

Among the findings: While 52% of all respondents indicated no religious struggle according to the seven negative religious coping items from the Brief RCOPE, 15% did give strong responses to at least two of the items, saying that the items were applicable "quite a bit" or "a great deal." For the total sample, the mean negative religious coping score was 2.2 (SD 3.4), out of a possible maximum score of 21. Of the demographic characteristics studied, only age was associated with negative religious coping, "with younger patients reporting higher scores" [p. 185]. "[I]n the multi-variate regression model, age had a significant inverse association with

negative religious coping" [p. 187]. Also, "those who attended worship at least once a week or more reported the lowest religious coping scores...[and] the highest scores were from those who rarely attended worship" [p. 185]. And with regard to mental distress, "negative religious coping was associated with higher levels of emotional distress and depressive symptoms in all three patient groups...[and] and with higher levels of anxiety and hostility in the CHF patients" [pp. 187, 189]. Speculation about factors that may underlie these findings is offered in the Discussion section on pp. 189-192.

One further finding that suggests the complexity of religious coping was that "higher levels of positive religious coping were associated with higher levels of negative religious coping, except for those with mid-range positive religious coping scores" [p. 187]. So, just because someone may frequently use positive religious coping does not preclude religious struggle. "Positive religious coping is not the opposite of negative religious coping" [p. 191]. The authors write:

> It is possible that the relationship between the two measures [of positive and negative religious coping] may take at least two forms. For some, religion may be a source of comfort and strength, unburdened by guilt or doubt. In contrast, others may make frequent use of religion to cope with illness or other stressful events and this coping may have positive as well as negative elements. In the present study, evidence for the second pattern is seen in highest mean negative religious coping score among those with the highest level of positive religious coping. [p. 191]

Of course, these findings are dependent upon the validity and reliability of the Brief RCOPE, which does appear to be a good measure but still one with limitations. The authors note that "the items in the negative religious coping subscale...assume a belief in God and the devil, as well as involvement in a religious congregation" [p. 192]. They point out several other measures that may be useful in future research.

Participation rates for this study were fairly good (i.e., 67% for the diabetic population, 88% for the oncology population, and 50% for the CHF population), but the most frequently cited reason for declining participation was because of feeling ill [see p. 182]. From this the authors caution: "If physical symptoms increase religious struggle, this sampling bias may have created an underestimation of the extent of religious struggle..." [p. 192]. Still, it is significant that as many as 15% of patients "may have levels of religious struggle that place them at risk for poor physical or mental health outcomes" [p.192].

Suggestions for the Use of the Article for Discussion in CPE:

This article would seem to be suited for students who have already had some introduction to pastoral care research and have a basic sense of how to work with the statistics involved. However, it is written so well as to engage any reader from the opening paragraphs onward. Chaplains should not only be able to identify with the subject matter but should appreciate that the authors obviously have a subtle understanding of the role of religion in patients' lives (and two are members of the ACPE: George Fitchett and James L. Gibbons). Discussion could center on the concepts of positive religious coping and negative religious coping, especially as the latter is illustrated by items in the Brief RCOPE (given in Table 2, p. 187). Chaplains with some experience in pastoral visitation may want to reflect upon patient cases where they have seen religious struggle as a factor affecting the course of a hospitalization, and then think about how the present article relates to their experience. Students may also want to consider the finding that younger patients may be at greater risk of religious struggle than older patients, and how this may play into their practice of pastoral care assessment.

Other Items of Interest:

I. The following three studies are cited in this month's featured article [p. 181], supporting the idea that religious struggle may negatively affect health outcomes. These studies were also suggested by George Fitchett in a bibliography on "spiritual risk" which was part of the March 2003 Article-of-the-Month page.

Fitchett, G., Rybarczyk, B. D., DeMarco, G. A. and Nicholas, J. J. "**The role of religion in medical rehabilitation outcomes: a longitudinal study**." *Rehabilitation Psychology* 44, no. 4 (November 1999): 333-353.

Koenig, H. G., Pargament, K. I. and Nielsen, J. "**Religious coping and health status in medically ill hospitalized older adults**." *Journal of Nervous and Mental Disease* 186, no. 9 (September 1998): 513-521.

Pargament, K. I., Koenig, H. G., Tarakeshwar, N. and Hahn, J. "**Religious struggle as a predictor of mortality among medically ill elderly patients: a two-year longitudinal study**." *Archives of Internal Medicine*161, no. 15 (August 13-17, 2001): 1881-1885.

II. The April 2003 Article-of-the-Month page gives a bibliography for a basic introduction to religious coping, including the following study that specifically presents the development of the Brief RCOPE measure.

Pargament, K. I., Smith, B. W., Koenig, H. G. and Perez, L. "**Patterns of positive and negative religious coping with major life stressors**." *Journal for the Scientific Study of Religion* 37, no. 4 (December 1998): 710-724.

[Added 7/29/05:] Manning-Walsh, J. "**Spiritual struggle: effect on quality of life and life satisfaction in women with breast cancer**." *Journal of Holistic Nursing* 23, no. 2 (June 2005): 120-140, with discussion on pp. 141-144.

[Added 3/10/05:] Pargament, K. I., Koenig, H. G., Tarakeshwar, N. and Hahn, J. "**Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: a two-year longitudinal study**." *Journal of Health Psychology* 9, no. 6 (November 2004): 713-730.

[ADDED 12/27/05]: Sherman, A. C., Simonton, S., Latif, U., Spohn, R. and Tricot, G. "**Religious struggle and religious comfort in response to illness: health outcomes among stem cell transplant patients**." *Journal of Behavioral Medicine* 28, no. 4 (August 2005): 359-367. [This study of 213 multiple myeloma patients during their initial work-up for autologous stem cell transplantation found that negative religious coping was associated with significantly poorer functioning on outcomes for depression, distress, mental health, pain, and fatigue; but general religiousness or positive religious coping was not associated with any of the outcomes measured.]

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