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October 2014 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Trevino, K. M., Balboni, M., Zollfrank, A., Balboni, T. and Prigerson, H. G. "**Negative religious coping as a correlate of suicidal ideation in patients with advanced cancer**." *Psycho-Oncology* 23, no. 8 (August 2014): 936-945.

SUMMARY and COMMENT: The work of Kelly M. Trevino, Michael Balboni, Angelika Zollfrank, Tracy Balboni, and Holly Prigerson should be familiar to most Network members from previous citations on our website (and ACPE Supervisor Zollfrank presented the well-received workshop on "…Learning Research to Enhance CPE Supervision" at the ACPE's 2014 national conference). In this study, they present data supporting an association between Negative Religious Coping (NRC) and suicidal ideation which may have implications for the development of targeted assessments and interventions with advanced cancer patients.

This study emerged from a larger *Coping with Cancer* research initiative {--see Related Items of Interest, §I, below] and analyzed data from seven sites regarding 603 patients who completed measures for NRC and suicidal ideation [--see p. 937]. Religious coping was assessed by the popular Brief RCOPE, as part of a battery of eleven instruments, included assessments of secular coping, global religiousness/spirituality, and spiritual care, in addition to demographic items [--see pp. 937-938]. In light of other studies, the researchers hypothesized "that NRC will be associated with an increased risk for suicidal ideation after controlling for significant demographic and disease and risk and protective factors" [and] "that the relationship between NRC and suicidal ideation will be stronger for participants who are female, white, older, and of lower income levels" [p. 937].

The main findings:

> Endorsement of *any* NRC was associated with over two times the odds of suicidal ideation after controlling for disease and demographic characteristics, risk, and protective factors for suicidal ideation, and PRC [Positive Religious Coping], indicating that NRC is a robust and unique risk factor for an important psychiatric outcome. These findings are consistent with previous research on NRC and distress…though this study is the first to demonstrate an association between NRC and suicidal ideation in advanced cancer patients. Notably, *any* utilization of NRC was associated with an increased risk for suicidal ideation. Even at low levels, NRC may be an important risk factor for psychiatric distress in cancer patients. [pp. 940 and 942; italics added].
>
> ...The interaction of NRC and potential moderating factors did not predict suicidal ideation for gender…, ethnicity…, age…, or income…. [p. 940]

The authors note that "the causal direction of the relationship between NRC and suicidal ideation cannot be determined from these cross-sectional data," but they speculate:

> NRC may represent a rift in a patient's worldview and relationship with God that leads to a sense of hopelessness, meaninglessness, and suicidal ideation. Conversely, feeling that life is not worth living may cause patients to feel abandoned and punished by God. [p. 942]

They go on to propose: "Assessment of NRC in patients with advanced cancer may serve the dual purpose of identifying patients experiencing spiritual distress and those at risk for suicidal ideation who would benefit from spiritual and/or psychiatric care" [p. 942]. Moreover:

> Integrating spiritual care providers into the treatment team may promote identification of patients using NRC strategies, treatment of spiritual distress, and reduction of suicidal ideation. These services could be designed to target NRC with early assessment and intervention. [p. 943]
>
> ...If confirmed in other samples, these findings suggest the need for the development of interventions that target NRC in patients with advanced cancer, particularly if current spiritually focused interventions do not reduce patients' risk of suicidal ideation. For example, cognitive therapy techniques that are sensitive to patients' religious and spiritual beliefs could target cognitions associated with NRC such as viewing cancer as a punishment from God. Evaluation of such techniques would result in empirically supported treatments for an important psychiatric outcome, suicidal ideation, in patients with advanced cancer. [p. 943]

While the Brief RCOPE measure was used to determine NRC here, the authors express some concern about its sensitivity: namely 1) that it may not discover low levels of NRC that could still be predictive of suicidal ideation, and 2) that its focus on "divine religious struggles, which are characterized by tension between the individual and the divine," may overlook "[i]nterpersonal spiritual struggles or spiritual conflicts with others and intrapersonal spiritual struggles or uncertainty or doubt about religious matters" [p. 942]. This reader would observe that since the very concept of negative and positive religious coping is dominated in the health care literature by the items of the Brief RCOPE measure, the concerns about it raised in the present article deserve particular attention.

The study's limits "include use of a religiously homogeneous Christian sample" and one that was somewhat skewed in terms of race, gender, and education. While the association found between NRC and suicidal ideation in this population is described as "robust" [p. 942], appropriate caution is offered regarding generalizations. The authors suggest avenues for research to understand better the relationship between NRC and suicidal ideation [p. 942] and potential spiritual care interventions [p. 943]. The bibliography is quite thorough, and there is a special explanatory note [p. 944] about the method of dichotomizing measures that supplements a generally detailed report of the data analysis.

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

This month's article would be more suited for students used to encountering statistics than for those new to the literature, but the key introductory and discussion sections should be generally quite comprehensible to everyone. Advanced students will want to explore the battery of instruments employed and their dichotomization, the idea of the "floor effect" of the Brief RCOPE, and the prospect of a "suppressor effect" [p. 942; i.e., presence of a suppressor variable]. Other students may discuss the broader themes and findings. A look at the specific items in the Negative Religious Coping subscale of the Brief RCOPE may be enlightening. Can students imagine a special relationship between these items and suicidal ideation in the context of advanced cancer? What do they make of the authors' speculation about a possible connection via a "rift in a patient's worldview and relationship with God that leads to a sense of hopelessness, meaninglessness, and suicidal ideation" [p. 942]? What do students think about targeting NRC in spiritual assessment and intervention? Are there ethical concerns about trying to change someone's religious coping even if it is "negative" and affects such

things as suicidal ideation? How might students respond to patients with advanced cancer expressing suicidal ideation?

Related Items of Interest:

I. This month's study was part of a broad *Coping with Cancer* research initiative from the National Cancer Institute and the National Institute of Mental Health. Other *Coping with Cancer* studies that have been conducted by some of the same authors and that may be of special interest to chaplains are:

> Balboni, T. A, Paulk, M. E., Balboni, M. J., Phelps, A. C., Loggers, E. T., Wright, A. A., Block, S. D., Lewis, E. F., Peteet, J. R. and Prigerson, H. G. "**Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death**." *Journal of Clinical Oncology*, 28, no. 3 (January 20, 2010): 445-452. [(Abstract:) PURPOSE: To determine whether spiritual care from the medical team impacts medical care received and quality of life (QoL) at the end of life (EoL) and to examine these relationships according to patient religious coping. PATIENTS AND METHODS: Prospective, multisite study of patients with advanced cancer from September 2002 through August 2008. We interviewed 343 patients at baseline and observed them (median, 116 days) until death. Spiritual care was defined by patient-rated support of spiritual needs by the medical team and receipt of pastoral care services. The Brief Religious Coping Scale (RCOPE) assessed positive religious coping. EoL outcomes included patient QoL and receipt of hospice and any aggressive care (eg, resuscitation). Analyses were adjusted for potential confounders and repeated according to median-split religious coping. RESULTS: Patients whose spiritual needs were largely or completely supported by the medical team received more hospice care in comparison with those not supported (adjusted odds ratio [AOR] = 3.53; 95% CI, 1.53 to 8.12, P = .003). High religious coping patients whose spiritual needs were largely or completely supported were more likely to receive hospice (AOR = 4.93; 95% CI, 1.64 to 14.80; P = .004) and less likely to receive aggressive care (AOR = 0.18; 95% CI, 0.04 to 0.79; P = .02) in comparison with those not supported. Spiritual support from the medical team and pastoral care visits were associated with higher QOL scores near death (20.0 [95% CI, 18.9 to 21.1] v 17.3 [95% CI, 15.9 to 18.8], P = .007; and 20.4 [95% CI, 19.2 to 21.1] v 17.7 [95% CI, 16.5 to 18.9], P = .003, respectively). CONCLUSION: Support of terminally ill patients' spiritual needs by the medical team is associated with greater hospice utilization and, among high religious copers, less aggressive care at EoL. Spiritual care is associated with better patient QoL near death.] [This study was highlighted as our January 2010 Article-of-the-Month.]

> Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, M. E., Lathan, C. S., Peteet, J. R. and Prigerson, H. G. "**Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life**." *Journal of Clinical Oncology* 25, no. 5 (February 10, 2007): 555-560. [(From the abstract:) PURPOSE: Religion and spirituality play a role in coping with illness for many cancer patients. This study examined religiousness and spiritual support in advanced cancer patients of diverse racial/ethnic backgrounds and associations with quality of life (QOL), treatment preferences, and advance care planning. METHODS: …Patients with an advanced cancer diagnosis and failure of first-line chemotherapy were interviewed at baseline regarding religiousness, spiritual support, QOL, treatment preferences, and advance care planning. RESULTS: Most (88%) of the study population (N = 230) considered religion to be at least somewhat important. Nearly half (47%) reported that their spiritual needs were minimally or not at all supported by a religious community, and 72% reported that their spiritual needs were supported minimally or not at all by the medical system. Spiritual support by religious communities or the medical system was significantly associated with patient QOL (P = .0003). Religiousness was significantly associated with wanting all measures to extend life (odds ratio, 1.96; 95% CI, 1.08 to 3.57). CONCLUSION: Many advanced cancer patients' spiritual needs are not supported by religious communities or the medical system, and spiritual support is

associated with better QOL. Religious individuals more frequently want aggressive measures to extend life.]

Maciejewski, P. K., Phelps, A. C., Kacel, E. L., Balboni, T. A., Balboni. M., Wright, A. A., Pirl, W. and Prigerson, H. G. "**Religious coping and behavioral disengagement: opposing influences on advance care planning and receipt of intensive care near death**." *Psycho-Oncology* 21, no. 7 (July 2012): 714-723,. [(Abstract:)] Objective: This study examines the relationships between methods of coping with advanced cancer, completion of advance care directives, and receipt of intensive, life-prolonging care near death. Methods: The analysis is based on a sample of 345 patients interviewed between January 1, 2003, and August 31, 2007, and followed until death as part of the Coping with Cancer Study, an NCI/NIMH-funded, multi-site, prospective, longitudinal, cohort study of patients with advanced cancer. The Brief COPE was used to assess active coping, use of emotional-support, and behavioral disengagement. The Brief RCOPE was used to assess positive and negative religious coping. The main outcome was intensive, life-prolonging care near death, defined as receipt of ventilation or resuscitation in the last week of life. Results: Positive religious coping was associated with lower rates of having a living will (AOR = 0.39, p = 0.003) and predicted higher rates of intensive, life-prolonging care near death (AOR, 5.43; p<0.001), adjusting for other coping methods and potential socio- demographic and health status confounds. Behavioral disengagement was associated with higher rates of DNR order completion (AOR, 2.78; p = 0.003) and predicted lower rates of intensive life-prolonging care near death (AOR, 0.20; p = 0.036). Not having a living will partially mediate the influence of positive religious coping on receipt of intensive, life-prolonging care near death. Conclusion: Positive religious coping and behavioral disengagement are important determinants of completion of advance care directives and receipt of intensive, life-prolonging care near death.

Phelps, A. C., Maciejewski, P. K., Nilsson, M., Balboni, T. A., Wright, A. A., Paulk, E. M., Trice, E., Schrag, D., Peteet, J. R., Block, S. D. and Prigerson, H. G. "**Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer**." *JAMA* 301, no. 11 (March 18, 2009): 1140-1147. [(Abstract:) CONTEXT: Patients frequently rely on religious faith to cope with cancer, but little is known about the associations between religious coping and the use of intensive life-prolonging care at the end of life. OBJECTIVE: To determine the way religious coping relates to the use of intensive life-prolonging end-of-life care among patients with advanced cancer. DESIGN, SETTING, AND PARTICIPANTS: A US multisite, prospective, longitudinal cohort of 345 patients with advanced cancer, who were enrolled between January 1, 2003, and August 31, 2007. The Brief RCOPE assessed positive religious coping. Baseline interviews assessed psychosocial and religious/spiritual measures, advance care planning, and end-of-life treatment preferences. Patients were followed up until death, a median of 122 days after baseline assessment. MAIN OUTCOME MEASURES: Intensive life-prolonging care, defined as receipt of mechanical ventilation or resuscitation in the last week of life. Analyses were adjusted for demographic factors significantly associated with positive religious coping and any end-of-life outcome at P < .05 (ie, age and race/ethnicity). The main outcome was further adjusted for potential psychosocial confounders (eg, other coping styles, terminal illness acknowledgment, spiritual support, preference for heroics, and advance care planning). RESULTS: A high level of positive religious coping at baseline was significantly associated with receipt of mechanical ventilation compared with patients with a low level (11.3% vs 3.6%; adjusted odds ratio [AOR], 2.81 [95% confidence interval {CI}, 1.03-7.69]; P = .04) and intensive life-prolonging care during the last week of life (13.6% vs 4.2%; AOR, 2.90 [95% CI, 1.14-7.35]; P = .03) after adjusting for age and race. In the model that further adjusted for other coping styles, terminal illness acknowledgment, support of spiritual needs, preference for heroics, and advance care planning (do-not-resuscitate order, living will, and health care proxy/durable power of attorney), positive religious coping remained a significant predictor of receiving intensive life-prolonging care near death (AOR, 2.90 [95% CI, 1.07-7.89]; P = .04). CONCLUSIONS: Positive religious coping in patients with advanced cancer is associated with receipt of intensive life-prolonging medical care

near death. Further research is needed to determine the mechanisms for this association.] [This study was highlighted as our April 2009 Article-of-the-Month.]

Spencer, R. J., Ray, A., Pirl, W. F. and Prigerson, H. G."**Clinical correlates of suicidal thoughts in patients with advanced cancer**." *American Journal of Geriatric Psychiatry* 20, no. 4 (April 2012): 327-236. [(Abstract:) OBJECTIVE: : Cancer patients are at heightened risk of suicide. Clinical correlates of suicidal ideation in advanced cancer patients were examined to identify those at risk and to inform the development of interventions to reduce suicidal ideation in this vulnerable group. METHODS: : Coping with Cancer (CwC) is an NCI- and NIMH-funded multiinstitutional investigation examining psychosocial influences on the quality of life and care of advanced cancer patients. Baseline face-to-face interviews that assessed mental and physical functioning, coping, spirituality, and use of mental health services were conducted with 700 advanced cancer patients. RESULTS: : Compared with patients without suicidal ideation, the 8.9% of patients who reported suicidal thoughts were more likely to be white and report no affiliation with an organized religion ($p < 0.05$). Adjusted analyses revealed that cancer patients who met criteria for current panic disorder (adjusted odds ratio [95% confidence interval] 3.24 [1.01-10.4]) and posttraumatic stress disorder (3.97 [1.13-14.1]), who accessed mental health services (3.70 [2.07-6.67]), particularly psychotherapy (2.62 [1.20-5.71]), who were not feeling well physically, and who lacked a sense of self-efficacy, spirituality, and being supported were more likely than others to report thoughts of suicide ($p < 0.05$). CONCLUSIONS: : Advanced cancer patients who report suicidal thoughts are more likely to meet criteria for posttraumatic stress disorder and panic disorder, feel unsupported, lack a religious affiliation, spirituality, and a sense of self-efficacy, and experience more physical distress. Palliative care interventions that promote a sense of self-efficacy, spirituality, and support while minimizing physical distress may offer promise for reducing suicidal thoughts in this at-risk group.]

II. Regarding pastoral care and suicidal patients, two studies have recently been published relating to veterans (note: *not* a cancer population).

Kopacz, M. S., McCarten, J. M. and Pollitt, M. J. "**VHA Chaplaincy Contact with Veterans at Increased Risk of Suicide**." *Southern Medical Journal* 107, no. 10 (October 2014): 661-664. [(Abstract:) OBJECTIVES: To examine the extent to which chaplains interact with military veterans at increased risk of suicide and select characteristics related to those at-risk veterans who present for chaplaincy services. METHODS: The nationwide network of chaplains affiliated with the Veterans Health Administration (n = 990) was e-mailed a letter inviting those who have contact with at-risk veterans to complete a survey. This letter included an Internet link, connecting respondents to an online survey collection service. One hundred eighteen chaplains (11.91%) responded to the survey. RESULTS: More than half of the respondents reported that veterans at increased risk of suicide constitute either <5% or 5% to 10% of the overall population of veterans under their care. At-risk veterans are most often identified based on open admission of suicidal behavior or red flags in their treatment file. Veterans typically do not look for chaplains from their own faith tradition, will seek care from >1 chaplain, and present at a moderate-to-high level of risk. CONCLUSIONS: The present study finds that some at-risk veterans look to chaplains for supportive services. The findings also allow for opportunities for future research.] [Note: co-author Michael J. Pollitt is a chaplain. See also in the same issue of the journal: Aycock, R. D., "Commentary on 'VHA Chaplaincy Contact with Veterans at Increased Risk of Suicide,'" p. 665.]

Kopacz, M. S. "**Providing pastoral care services in a clinical setting to veterans at-risk of suicide**." *Journal of Religion & Health* 52, no. 3 (September 2013): 759-767. [(Abstract:) The value of enhanced spiritual wellbeing has largely been overlooked as part of suicide prevention efforts in Veterans. The aim of this qualitative study is to examine the clinical pastoral care services provided by VA Chaplains to Veterans at-risk of suicide. This study was conducted using in-depth interviews with five Chaplains affiliated with a medical center located in upstate New York. This

study was able to show that some at-risk individuals do actively seek out pastoral care, demonstrating a demand for such services. In conclusion, a pastoral care framework may already exist in some clinical settings, giving at-risk Veterans the opportunity to access spiritual care.]

III. Regarding positive and negative religious coping and suicidality among psychiatric patients [note: *not* oncology], see the following recent research:

Rosmarin, D. H., Bigda-Peyton, J. S., Ongur, D., Pargament, K. I. and Bjorgvinsson, T. "**Religious coping among psychotic patients: relevance to suicidality and treatment outcomes**." *Psychiatry Research* 210, no. 1 (November 30, 2013): 182-187. [Religious coping is very common among individuals with psychosis, however its relevance to symptoms and treatment outcomes remains unclear. We conducted a prospective study in a clinical sample of n=47 psychiatric patients with current/past psychosis receiving partial (day) treatment at McLean Hospital. Subjects completed measures of religious involvement, religious coping and suicidality prior to treatment, and we assessed for psychosis, depression, anxiety and psychological well-being over the course of treatment. Negative religious coping (spiritual struggle) was associated with substantially greater frequency and intensity of suicidal ideation, as well as greater depression, anxiety, and less well-being prior to treatment (accounting for 9.0-46.2% of the variance in these variables). Positive religious coping was associated with significantly greater reductions in depression and anxiety, and increases in well-being over the course of treatment (accounting for 13.7-36.0% of the variance in change scores). Effects remained significant after controlling for significant covariates. Negative religious coping appears to be a risk factor for suicidality and affective symptoms among psychotic patients. Positive religious coping is an important resource to this population, and its utilization appears to be associated with better treatment outcomes.]

IV. For overviews of religion/spirituality and suicide, see:

Gearing, R. E. and Lizardi, D. "**Religion and suicide**." *Journal of Religion & Health* 48, no. 3 (September 2009): 332-341. [(Abstract:) Religion impacts suicidality. One's degree of religiosity can potentially serve as a protective factor against suicidal behavior. To accurately assess risk of suicide, it is imperative to understand the role of religion in suicidality. PsycINFO and MEDLINE databases were searched for published articles on religion and suicide between 1980 and 2008. Epidemiological data on suicidality across four religions, and the influence of religion on suicidality are presented. Practice guidelines are presented for incorporating religiosity into suicide risk assessment. Suicide rates and risk and protective factors for suicide vary across religions. It is essential to assess for degree of religious commitment and involvement to accurately identify suicide risk.]

Koenig, H. G., King, D. E. and Carson, V, B. ***Handbook of Religion and Health***. Second Edition. New York: Oxford University Press, 2012. [See Chapter 8: "Suicide" (pp. 174-190) for an overview of research. Excerpt from p. 190: "In a systematic review of the literature, we have identified 141 peer-reviewed quantitative studies examine the relationship between R/S [religion/spirituality] involvement and suicidal ideation, suicide attempts, and completed suicide. Of those studies, 106 {75 percent) found lower suicidal ideation and behaviors among those who were more religious; 27 reported no association; and only 4 studies found a positive association between R/S and suicide (each with serious methodological weaknesses)."]

And, the July 2007 issue of the *Southern Medical Journal* contains a special section of short essays on Spirituality, Depression & Suicide (pp. 733-756) that may be of special interest to chaplains. These are, in order of appearance:

Blazer, D. G. "**Section Introduction: Spirituality, Depression & Suicide**." *Southern Medical Journal* 100, no. 7 (July 2007): 733-734.

Blazer, D. "**Spirituality, depression and suicide: a cross-cultural perspective**." *Southern Medical Journal* 100, no. 7 (July 2007): 735-736.

Koenig, H. G. "**Spirituality and Depression: A Look at the Evidence**." *Southern Medical Journal* 100, no. 7 (July 2007): 737-739.

Cloninger, C. R. "**Spirituality and the Science of Feeling Good**." *Southern Medical Journal* 100, no. 7 (July 2007): 740-743.

Josephson, A. M. "**Depression and suicide in children and adolescents: a spiritual perspective**." *Southern Medical Journal* 100, no. 7 (July 2007): 744-745.

Bostwick, J. M. and Rummans, T. A. "**Spirituality, depression and suicide in middle age**." *Southern Medical Journal* 100, no. 7 (July 2007): 746-747.

Steffens, D. C. "**Spiritual considerations in suicide and depression among the elderly**." *Southern Medical Journal* 100, no. 7 (July 2007): 748-749.

Dunlap, S. J. "**Suicide: A Clinical-Pastoral Perspective**." *Southern Medical Journal* 100, no. 7 (July 2007): 750-751.

Peteet, J. "**Suicide and Spirituality: A Clinical Perspective**." *Southern Medical Journal* 100, no. 7 (July 2007): 752-754.

Meglin, D. E. "**Suicide: Where Can Help Be Found?**" *Southern Medical Journal* 100, no. 7 (July 2007): 755-756.

V. Note that our Winter-Spring 2014 *Newsletter*, §7, rported a new national survey from the Pew Research Center's Forum on Religion and Public Life, "Views on End-of-Life Medical Treatments;" which included the finding:

> [A] growing share of Americans…believe individuals have a moral right to end their own lives. About six-in-ten adults (62%) say that a person suffering a great deal of pain with no hope of improvement has a moral right to commit suicide, up from 55% in 1990. A 56% majority also says this about those who have an incurable disease, up from 49% in 1990. [--from the report's Overview, p. 7]

For more, see Chapter 2: "Views on the Morality of Suicide" in the complete report.

If you have suggestions about the form and/or content of the site, e-mail Chaplain John Ehman (Network Convener) at john.ehman@uphs.upenn.edu .

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