January 2014 Article of the Month

This month's article selection is by Chaplain John Ehman,
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McLaughlin, B., Yoo, W., D'Angelo, J., Tsang, S., Shaw, B., Shah, D., Baker, T. and Gustafson, D. "**It is out of my hands: how deferring control to God can decrease quality of life for breast cancer patients**." *Pscyho-Oncology* 22 no. 12 (December 2013): 2747-2754.

SUMMARY and COMMENT:

This month's article, out of the University of Wisconsin, explores how a *deferring* style of religious coping "can simultaneously lead to positive and negative health outcomes" [p. 2748], using a population of women treated for breast cancer. Their findings support "a mediation model predicting that when women with breast cancer find meaning for and relief from their illness by deferring control to God, they may adopt a passive coping style, which may ultimately result in lower quality of life" [p. 2751]. The study should be of practical value to clinical chaplains in better elucidating the dynamics of religious coping, and it also raises fruitful questions for further pursuit by chaplain researches.

Data were gleaned by an intriguing method of computerized content analysis of posts by 192 participants (from a larger study [--see Items of Related Interest §IV, below]) to an online discussion forum hosted by the Comprehensive Health Enhancement Support System (CHESS) at the University of Wisconsin. The computer coding rules were subjected to a reliability test on 100 random posts, with a reported 100% agreement between two coders. The researchers employed an action log system that allowed them to pair posts with individuals, and they also used "longitudinal survey data, which were collected prior to use of CHESS and 6 months after having access to the system" [p. 2749]. "Deferring control to God was operationalized as the total counts of deferring control to God-related messages...divided by the total number of messages posted...for a 6-month study period" [p. 2750]. Breast cancer-related concerns, problem-focused coping (active coping and planning), and quality of life were measured by items of the Functional Assessment of Cancer Therapy Scale, Brief COPE Scale, and World Health Organization Quality of Life BRIEF Scale, respectively [--see Table 2, p. 2750].

The authors graphically illustrate their theorized model and its pathways [--see Figure 1, p. 2748] and explain:

> Our theoretical model predicts that when women with breast cancer find meaning for their illness by deferring control to God, they may experience fewer concerns about their breast cancer. At the same time, deferring control will also reduce the likelihood that breast cancer patients see the need to take a proactive coping approach. This behavior should be exacerbated by lowered breast cancer concerns. Because women who defer control will be less likely to take proactive coping approaches, they will ultimately report lower quality of life. [p. 2748]

A comparable graphic of their findings [--see Figure 2, p. 2751] is very helpfully provided.

Their hypotheses and results:

> **Hypothesis #1**: "Deferring control to God will lead to lower levels of breast cancer related concerns." [p. 2748]
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> SUPPORTED -- "Deferring control to God was negatively associated with breast cancer related concerns, suggesting that women who deferred control had fewer breast cancer related concerns." [p. 2751]
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> **Hypothesis #2a**: "Deferring control to God will lead to lower levels of problem-focused coping." [p. 2748]
> **Hypothesis #2b**: "Lower levels of breast cancer related concerns will lead to lower levels of problem-focused coping." [p. 2749]
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> SUPPORTED -- "Deferring control to God was negatively related to problem-focused coping, suggesting that women who deferred control were less likely to adopt active coping...planning.... In addition, breast cancer related concerns were positively related to problem-focused coping...and planning.... In other words, women with lower levels of breast cancer related concerns were less likely to adopt problem-focused coping." [p. 2751]
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> **Hypothesis #3**: "Lower levels of problem-focused coping will result in lower levels of quality of life for breast cancer patients." [p. 2749]
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> PARTIALLY SUPPORTED -- "...[A]ctive coping was positively associated with quality of life.... Patients with lower levels of active coping, therefore, tended to report lower levels of quality of life. However, there was no significant relationship between planning and quality of life." [p. 2751]
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> **Hypothesis #4a**: "Deferring control to God will exert an indirect effect on quality of life via problem-focused coping, suggesting that deferring control to God will lead to lower levels of problem-focused coping, which will lead to lower levels of quality of life." [p. 2749]
> **Hypothesis #4b**: "Deferring control to God will exert an indirect effect on quality of life via breast cancer-related concerns and problem-focused coping, suggesting that deferring control to God will lead to lower levels of breast cancer concerns, which will lead to lower levels of problem-focused coping, leading to lower levels of quality of life." [p. 2749]
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> PARTIALLY SUPPORTED -- "...[D]eferring control was found to exert a significant indirect effect on quality of life via active coping...but not planning. As another significant pathway, deferring control predicted less breast cancer related concerns and then led to lower levels of active coping, but not planning, which finally resulted in reduced quality of life...." [p. 2751]

"In sum, the effect of deferring control to God on quality of life was fully mediated by breast cancer related concerns and/or active coping." [p. 2751]

The authors further summarize:

> ...We find support for most of our predicted pathways, including a significant negative relationship between deferring control and breast cancer related concerns and a negative relationship between deferring control and problem-focused coping {active coping and planning}. Additionally, as breast cancer concerns goes down, so does problem-focused coping. We also see that as active coping goes down, quality of life does, as well. We did not, however, find that planning was significantly correlated with quality of life. This was the only pathway that did not confirm our expectations. Finally, we find significant indi- rect effects of deferring control to God through breast cancer concerns, to active coping, then to quality of life. Similarly, we found a significant indirect effect for deferring control, through active coping, on quality of life. [p. 2751]

These results then show the potential for both positive and negative health effects from deferring religious coping, and the authors are emphatic that their study should not be taken as dismissing the benefits of this coping style. They even point (from other work [see Items of Related Interest, §II, below]) to the possibility that

a deferring approach may be especially valuable in circumstances like that of palliative care, when a patient may be "faced with an intractable situation" [p. 2752]. Overall, however, they are clearly concerned about possible deleterious effects and prefer and argue for a shift from a deferring coping style to a collaborative one. "The collaborative approach posits that the problem-solving responsibility is shared equally between God and the individual" [pp. 2747-2748]. "Collaborative coping still provides those with serious illness a means of easing existential concerns, yet it may not come at the cost of proactive coping" [p. 2752]. And, in the Discussion section, they go so far as to state: "It is therefore important for healthcare practitioners to encourage patients who are relying on religion to remember that they have to keep their end of the bargain" [p. 2752]. [Note: for this reader, the latter exhortation (also prominent in the official abstract) seems out of character from the careful wording of the rest of the article, since it appears to have health care practitioners act as religious counselors and promote a *theological* position that patients "have to keep their end of the bargain."]

The authors appropriately temper their findings in light of study limits [--see p. 2752], including relatively small effect sizes, and they go on to suggest, "Future studies may wish to build off of our model by considering additional pathways (e.g., emotion-focused coping) and potential factors (e.g., stage of illness, religious affiliation) and/or test our model in different contexts" [p. 2752]. Chaplain researchers might be in a good position to take up the authors' call to "consider the relationship between religion and health in more theoretically driven, nuanced ways" [p. 2752] and to investigate religious coping styles in particular.

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

The statistical analysis in this article may be hard for newer students to follow at first, but the two graphic illustrations of the theorized relationships and findings (Figures 1 and 2, pp. 2748 and 2751) not only make plain the connections and pathways but could be used to engage students in a discussion of basic statistics per se. The straightforward enumeration of the study's hypotheses could also be a structure for discussion by taking them one at a time. However, the overall topic of the article is certainly rich for discussion: What do students think of the mix of potential effects of a deferring religious coping style? How have students seen examples of deferring coping in their pastoral work, and what are the theological bases and implications of deferring to God in matters of health? How might the findings of this study affect chaplains' thinking about patients' who make deferring expressions? Would students ever encourage patients to take rather a collaborative coping style as healthier? Finally, students might want to discuss issues of generalizability in these findings in light of the study's limits as addressed in the Discussion section [--see p. 2752] and the fact that the data came from 2004-2006.

Related Items of Interest:

I. For the classic source on religious coping styles, see Pargament, K. I., ***The Psychology of Religion and Coping: Theory, Research, Practice*** (New York: Guilford, 1997). By the way, ACPE Supervisor Margot Hover reviewed this book in *Psycho-Oncology* 8, no. 5 (1999): 460-461.) A good and recent overview of the coping literature would be: Pargament, K. I., "**Religion and coping: the current state of knowledge**," pp. 269–288 in Folkman, S. (ed.), *Oxford Handbook of Stress, Health, and Coping* (New York: Oxford University Press, 2011).

II. Regarding the idea that a deferring coping style may be especially advantageous in *intractable* health situations, our authors cite: Kevern, P., "In search of a theoretical basis for understanding religious coping: initial testing of an explanatory model," *Mental Health, Religion and Culture* 15, no. 1 (2012): 23-37. The Kevern article actually makes that point by citing an older study:

Bickel, C., Ciarrocchi, J. W., Sheers, N. J., Estadt, B. K., Powell, D. A. and Pargament, K. I. "**Perceived stress, religious coping styles, and depressive affect**." *Journal of Psychology and Christianity* 17, no. 1 (1998): 33-42. [(Abstract:) The relationships between perceived stress and religious coping styles with depressive affect were investigated in 245 adult members of Presbyterian churches (mean age 53.3 yrs). The 3 instruments used were the Perceived Stress Scale, the Religious Coping Styles Questionnaire, and the Beck Depression Inventory. It was hypothesized that as the reported use of the self-directing religious coping increased, there would be an associated increase in depressive affect under conditions of high stress. It was further hypothesized that as the reported use of the collaborative style increased, in conditions of high stress, there would be an associated decrease in depressive affect. The results were in accordance with expectations.]

III. Our featured article's bibliography of 60 references offers many good leads for further reading, but below are a few additional titles that are not cited but may be of interest:

Burker, E. J., Evon, D. M., Sedway, J. A., & Egan, T. "**Religious coping, psychological distress and disability among patients with end-stage pulmonary disease**." *Journal of Clinical Psychology in Medical Settings* 11, no. 3 (September 2004): 179-193. [(Abstract:) A growing body of literature suggests that individuals who face life-threatening situations turn to religion to help them cope. Religion has been cited as the most frequently used resource to cope with stressful events (K. I. Pargament, 1997). The present study was the first to investigate the religious coping methods of patients with lung disease who are awaiting transplant and to identify which coping methods are associated with distress and disability. The study was an exploratory, cross-sectional analysis of 90 patients with end-stage pulmonary disease who were being evaluated for transplant. Results indicated that religiosity was highly prevalent. Patients employed a combination of religious coping efforts, but mostly used coping methods considered "positive." Patients with late-onset pulmonary diseases used religious coping strategies more frequently than patients with cystic fibrosis. Hierarchical regression analyses identified a subset of religious coping strategies that predicted 27%, 14%, and 34% of the unique variance in depression, overall disability, and psychosocial disability, respectively.] [Note: These same authors also produced our January 2006 Article-of-the-Month: "**Religious and non-religious coping in lung transplant candidates: Does adding God to the picture tell us more?**"

Grossoehme, D. H., Opipari-Arrigan, L., VanDyke, R., Thurmond, S. and Seid, M. "**Relationship of adherence determinants and parental spirituality in Cystic Fibrosis**." *Pediatric Pulmonology* 47, no. 6 (June 2012): 558-566. [(Abstract:) The course of cystic fibrosis (CF) progression in children is affected by parent adherence to treatment plans. The Theory of Reasoned Action (TRA) posits that intentions are the best behavioral predictors and that intentions reasonably follow from beliefs ("determinants"). Determinants are affected by multiple "background factors," including spirituality. This study's purpose was to understand whether two parental adherence determinants (attitude towards treatment and self-efficacy) were associated with spirituality (religious coping and sanctification of the body). We hypothesized that parents' attitudes toward treatment adherence are associated with these spiritual constructs. A convenience sample of parents of children with CF aged 3-12 years (n = 28) participated by completing surveys of adherence and spirituality during a regular outpatient clinic visit. Type and degree of religious coping was examined using principal component analysis. Adherence measures were compared based on religious

coping styles and sanctification of the body using unpaired t-tests. Collaborative religious coping was associated with higher self-efficacy for completing airway clearance (M = 1070.8; SD = 35.8; P = 0.012), for completing aerosolized medication administration (M = 1077.1; SD = 37.4; P = 0.018), and for attitude towards treatment utility (M = 38.8; SD = 2.36; P = 0.038). Parents who attributed sacred qualities to their child's body (e.g., "blessed" or "miraculous") had higher mean scores for self-efficacy (airway clearance, M = 1058.6; SD = 37.7; P = 0.023; aerosols M = 1070.8; SD = 41.6; P = 0.020). Parents for whom God was manifested in their child's body (e.g., "My child's body is created in God's image") had higher mean scores for self-efficacy for airway clearance (M = 1056.4; SD = 59.0; P = 0.039), aerosolized medications (M = 1068.8; SD = 42.6; P = 0.033) and treatment utility (M = 38.8; SD = 2.4; P = 0.025). Spiritual constructs show promising significance and are currently undervalued in chronic disease management.]

Nairn, R. C. and Merluzzi, T. V. "**The role of religious coping in adjustment to cancer**." *Psycho-Oncology* 12, no. 5 (July-August 2003): 428-441. [(Abstract:) This study tested a model of adjustment to cancer in which social support, disease impact, and religious coping were hypothesized to have an impact on adjustment to cancer that was mediated by self-efficacy. Two hundred and ninety-two people with cancer completed questionnaires. Three analyses were undertaken: first, the structure of the Religious Problem Solving Scale was assessed by a factor analysis in which two factors emerged, Deferring-Collaborative and Self-Directing; second, the resulting factors' relationships to outcome measures were assessed through correlational and regression analyses; third, a mediated model of coping was tested with self-efficacy as a mediating variable between religious coping and adjustment. The Deferring-Collaborative factor had positive relationships with most of the variables and was partially mediated by self-efficacy. The results indicate that religious coping has no relationship to quality of life, a positive relationship with adjustment, and was more important in this study than available social support.]

Ross, K., Handal, P. J., Clark, E. M. and Vander Wal, J. S. "**The relationship between religion and religious coping: religious coping as a moderator between religion and adjustment**." *Journal of Religion and Health* 48, no. 4 (December 2009): 454-467. [(Abstract:) This study examined the relationship between and among religion, religious coping, and positive/negative psychological adjustment and investigated whether the four religious coping styles of Self-Directing, Deferring, Collaborative, and Turning to Religion would significantly moderate the relationship between religion and psychological adjustment. Each of the four religious coping measures were significant moderators between religion and positive and negative adjustment. However, the high self-directing and high religion group showed opposite results from the other three coping styles, in that they were the most maladjusted and least satisfied with life compared to the other three integration and religious coping groups. The participants high on religion and high deferring, high collaborative, and high turning to religion groups were less maladjusted and more satisfied than the other three groups in each of these religious coping styles.]

IV. The larger study from which the present one emerged (but which does *not* address religious coping) is reported in:

Hawkins, R. P., Han, J. Y., Pingree. S., Shaw, B. R., Baker, T. B. and Roberts, L. J. "**Interactivity and presence of three eHealth interventions**." *Computers in Human Behavior* 26, no. 5 (September 2010): 1081-1088. [(Abstract:) A number of researchers have identified interactivity and presence as potentially important

attributes of eHealth applications, because they are believed to influence users to interact with systems in ways that increase commitment, learning, and other desirable responses. This paper reports on the development of brief scales to assess the two concepts, and on use of them with participants in six conditions of a large-scale trial of interventions for breast cancer patients. Overall, the Internet scored very low on both measures. Versions of an integrated system of services (CHESS) scored higher, particularly as conditions added features to different versions of the system. Interventions involving a human Cancer Information Mentor scored highest, though even the Mentor was perceived as more interactive and having more presence when combined with the integrated eHealth system.]
