

A GENERAL PERSPECTIVE ON THE IMPACT THAT RELIGIOUS AND SPIRITUAL BELIEFS HAVE WHILE ADAPTING TO NEOPLASTIC DISEASE.

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Apparently, religious orientation, religious and spiritual beliefs are regarded as important factors in adapting to the disease. Religious orientation as opposed to religious coping is seen as having a lower impact on one's adapting to the disease from the perspective of life quality. It is supposed that both religious orientation and religious coping are equally efficient in increasing one's life quality. The aim of the research is to highlight how the spiritual (inner peace, faith, meaning) and religious factors (religious coping and religious orientation), as predictors of increasing quality of life, contribute to increasing the quality of life of cancer patients. The sample is made up of cancer patients (161), mixed sample, women and men, between the ages of 30 and 70, admitted to the Radiotherapy of the Municipal Hospital of Timisoara. We are using the following instruments: Brief Measure of Religious Coping (RCOPE- Pargament K.I., Smith B.W., Koenig H.G. and Perez L., 1998), Quality of Life in Adult Cancer (QLAC - Nancy E. A., Smith K.W., McGraw S., Smith R.G., Petronis V.M and Carver C.R.), Religious Orientation Scale Revised (ROS-R- Gorsuch R.L. and McPherson S.E., 1989), Functional Assessment of Chronic Illness Therapy - Spiritual Wellbeing Scale (Andrea L. Canada, Patricia E. Murphy, George Fitchett, Amy H. Peterman și Leslie R. Schover, in 2007). Hierarchical multiple regression was used in data analysis. The results of the study indicate that the factors with the highest weight in explaining the majority of the quality of life are: personal extrinsic religious orientation, negative religious coping and inner peace.

Key-words: religious orientation, religious coping, the state of spiritual well-being, neoplastic disease, adaptation to neoplastic disease.

A survey of the data presented in specialised literature:

Cancer, as opposed to other chronic diseases, is regarded as having the highest destructive potential for an individual, being the most frightening disease. Social perception of this disease is linked to being quickly sentenced to death. The treatment that the ill person is exposed to is a very aggressive one, with major side effects affecting life quality. This disease makes the patient face one of the main fears of human beings and that is – one's own death. Fear of death, of no longer being alive, activates individual's self-defence/ self-conservation and at the same time determines the ill person to ask oneself fundamental questions connected to the significance of life and death. The ill person, facing one's own death, activates one's own coping mechanisms in order to face the threat, being susceptible to developing a series of new reactions

and behaviours which have the very purpose of succeeding in managing the wave of new emotions and thoughts that one confronts with. Specialised literature mentions the fact that among the symptoms most frequently developed by an ill person, one can find those of anxiety and depression.

In 2001, Koenig, Larson, and Larson emphasise the fact that religion and spirituality play an important role in one's adapting to cancer and that is the one of finding significance and meaning to the disease, of maintaining one's hope of healing alive and also of helping one explain and control the disease. All these elements are very important in adapting to the disease because they have the role of reducing the pressure associated to the disease. Attributing the uncontrollable and the intolerable to God, the ill person finds peace in the belief that God is present and supportive of human suffering (Gall & Cornblat, 2002). Transposing religious beliefs into behavioural patterns ensures the individual's pressure relief, the maintaining, for a period of time, of a state of peacefulness and inner comfort, as well as the satisfaction of the ritual needs imposed by each religion at a time.

One can notice that one can find much more powerful and more transparent connections, if one measures the strategy of religious coping and not the religious dispositions in general. As religious dispositions indicate religious involvement in general, religious coping directs and focalises the specific way in which the patient becomes more interested in religion at times of crisis (Pargament, 1997; Sherman and Simonton, 2001). Also, a more detailed analysis of religious coping provides information connected to the functional aspects of religion which can be more or less distinct as opposed to religious dispositions. In several studies made based on different samples than those of oncologic patients, which examined the specific types of religious coping, one emphasises the fact that adaptation to difficult circumstances is better predicted by coping strategies than religious orientation (Pargament, 1990). From this perspective, the strategies of religious coping present differentiated relations of results in connection with various life situations which presuppose the existence of pressure. More specifically, religious coping was found as beneficial or damaging according to the particular type of coping strategy involved. Also, religious coping appears as an ambivalent phenomenon which does not automatically involve beneficial results too.

A more detailed analysis highlights the fact that particular methods of religious coping can be classified into two global patterns: positive and negative religious coping (Pargament, 1998). Generally, the strategies of positive religious coping are those which reflect a fully confident and constructive turn to religion for support, these having the tendency of being beneficial to persons facing a stressful event in their lives (Vasconcelles, 2005; Koenig, 2001). As opposed to this strategy, negative religious coping reflects a conflictual and full-of-doubts involvement in religion, which is generally less adaptive for a person.

Turning to cancer patients, one can find that some studies have examined religious coping strategies (Alferi, 1999; Carver, 1993; Nairn and Merluzzi, 2003; Sherman, 2000). In psycho-

oncologic research, these investigations have served as a means of turning one's attention from patient's religious disposition to one's specific answer to disease. There was a limited preoccupation for the various links between coping strategies, on the one hand, and religious conflict and doubt, on the other hand. Only recently, has Sherman (2005) investigated positive and negative religious coping on a sample made up of patients with multiple myeloma who had undergone bone marrow transplant. Results show that after the control of the demographic and medical factor influences, only negative religious coping obtained significant links as opposed to the differing results of the measurements connected to psychological-social adaptation. For the process of researching and caring for cancer patients, these discoveries underline the necessity of making a distinction between the different patterns of religious coping and of emphasising the importance that the influence of religious conflicts and doubts can have on the process of adaptation.

Besides the differentiation between positive and negative religious coping, there also are some doubts regarding the potential of religious coping strategies. One of these would be whether these religious coping strategies directly and solely contribute to psychological-social adaptation or rather whether these contribute to patient's adaptation through other ways, such as non-religious coping strategies (Siegel, 2001). This approach also appears in Pargament's studies, so religious coping can be a predictor of psychological-social adaptation, still only as a functional equivalent of traditional non-religious coping measurements.

If things were like this, there generally would not be any necessity of identifying the variables of religious coping as specific predictors of results obtained for adaptation to disease. Nevertheless, in the studies conducted among the members of Christian churches, who plan their life events in a serious manner, Pargament (1999) emphasises the fact that the variables of religious coping predict results for psychological-social adaptation more accurately than the effects of non-religious coping strategies. Similar results were obtained in a study conducted by Burker (2005), on a sample of subjects who needed a lung transplant, so the conclusion of the study was that religious and non-religious coping strategies are not functionally redundant, being independent components of psychological-social functioning.

Seen from a different perspective, religion is represented as a cognitive schema (Dull and Skokan, 1995), which can influence individual attitudes (control, optimism) to the meanings one attributes to life events, even disease. In their vision, religion is more than an affiliation to a group, it is a life philosophy which strongly affects the cognition of those who belong to that particular group and last but not least, individual's health. It is a central attitude or a personal disposition which can generally direct and guide individual's thoughts in the process of adaptation. As a life philosophy or personal predisposition, religion would be described more appropriately by the term spiritual or spirituality. The terms, religious and spiritual, are distinct constructs, but they superpose (Hill, Pargament, Hood, McCullough, Swyers, Larson, & Zinnbauer, 2000). While religion as a measure is associated to one's being religious, participating in religious service, spirituality is seen in much more personalized and experiential

terms. Both religion and spirituality are seen as connected to one's relation to God. Intrinsic religiousness and praying frequency also imply sacral essence and a process of searching that identifies and articulates what is sacred, maintains what is sacred and presupposes personal transformation (Hill et.al, 2000).

Thus, one's religious orientation can influence a person's individual answers to stressful life circumstances, such as one's state of illness. Religion as general guiding tool can take on two forms: extrinsic religiousness and intrinsic religiousness. Extrinsic religiousness is seen as a form of immaturity, of superficial orientation, which in the first place serves an individual's own ego. From this point of view, one's self is not reflected in one's relations with others but in the situation when they are seen as a means of helping the individual to increase one's comfort and security (Allport 1961, Hergenhahn & Olson, 1999).The practices of extrinsic religiousness are not oriented by beliefs; they are motivated by the feeling of guilt, anxiety and the sentiment of external pressure which consequently affect coping, results showing that they are less efficient in the process of adapting to neoplastic disease (Pargament, 1997).

Individual's faith and trust that disease lies at the basis of one's entire reality, of one's state of well-being, motivate intrinsic religiousness (Allport, 1961; Hergenhahn & Olson, 1999).Those intrinsically motivated live with their own beliefs which should bring them satisfaction and meaning to their lives. They are tempted to return to their religious beliefs during a time of crisis. Intrinsic religiousness was associated with an evaluation of one's potential of development and with one's commitment to coping centred on problem solving in connection with stressful situations in one's life.

Closely related to the effects of intrinsic religiousness, during one's fight against cancer, one can also mention the role that spirituality has. Spirituality can also include both transcendental experiences and religion. Spirituality is linked with one's own transcendental relation with a certain superior force. Oncologic patients' spiritual needs often include the need of finding meanings and hope, of having access to spiritual resources and also of giving meaning to the suffering they have been through. One can notice that the effects of spirituality are mostly similar to those of religious factors. However, spirituality plays a more important role in one's adaptation to disease compared to religious factors. This could be understood in the context of the effects that spirituality has on a person's whole psychological construction. Spirituality is rather connected to the way in which what one feels influences the way one thinks, while some religious factors are rather connected to the fact that the way in which one thinks can possibly influence what one feels.

Levine (2007) assesses a multi-racial sample of women with breast cancer and discovers that some women become more faithful as a result of confrontation with the disease, while others start asking themselves questions about their faith. Simonton (2007) also conducts a qualitative study examining the role of spirituality among African-American women suffering from breast cancer. On initial diagnosing, spirituality was found to facilitate the acceptance of disease,

guiding their treatment-related decisions and also ensuring their family support. Along the treatment stage, spirituality offered support in coping with effects that treatment produced and also help in finding meaning. Patients report the raising of their spirituality level and of their hope of survival. After the final stage of treatment, spirituality offers female patients a reason for survival, helps them dismiss the possibility of cancer relapse and also helps them adapt to treatment effects. For cancer patients in the final stages of disease, one discovers that those whose level of faith is higher report a better perception linked to life quality than those with a low level of faith.

Research methodology:

Hypotheses:

1. Oncologic patient's religious orientation significantly contributes to the raising of one's life quality.
2. Religious coping is a significant predictor of raising neoplastic patients' life quality.
3. Spiritual factors explain the raising of cancer patients' life quality.

Sample:

The participants (161) are persons diagnosed with cancer, admitted at the Municipal Hospital of Timișoara, who are under radio-therapeutic treatment. Among the study criteria, one does not pay attention to disease type, localisation and stage, with a sole remark in this respect, the study excludes the patients who are administered a palliative treatment. Also, this study does not include patients with relapse, those who suffer from significant pain or those who are immobile. The age of patients included in this study varies between 30-70, without differentiation from the point of view of this criterion. This is a mixed sample made up of both men and women.

Methods:

- Brief Measure of Religious Coping (RCOPE- Pargament K.I., Smith B.W. , Koenig H.G. and Perez L., 1998),
- Quality of Life in Adult Cancer (QLAC - Nancy E. A., Smith K.W., McGraw S., Smith R.G, Petronis V.M and Carver C.R.),
- Religious Orientation Scale Revised (ROS-R- Gorsuch R.L. and McPherson S.E., 1989),
- Functional Assessment of Chronic Illness Therapy - Spiritual Wellbeing Scale (Andrea L. Canada, Patricia E. Murphy, George Fitchett, Amy H. Peterman and Leslie R. Schover, 2007).

Results:

Religious factors are predictors of life quality improvement in neoplastic disease

Starting from the premise that religious factors contribute to life quality improvement, the obtained results support this theory, with a sole remark. Their share is still low and the highest influence can be found for psychological, social and spiritual dimensions as far as life quality is concerned.

Table 1. Results obtained following hierarchic regression for religious factor influence on life quality (N=161):

Predictor	ΔR^2	Coping positive rel.		Coping negative rel.		Intrinsic religiousness		Extrinsic religiousness. Pers		Extrinsic religiousness. Social	
		β	answer	β	answer	β	answer	β	answer	β	answer
Neg. feelings	0,43%			.16*	.15			-.24**	-.20		
Positive feelings	0,19%			-	-.30	.14	.11				
Cog. problems	0,24%	-.10	-.08	.25**	.24	.14	.11			.11	.10
Pain	0,21%			.11	.10			.15	.13		
Tiredness	0,33%							.12	.10	-.18*	-.16
Sexual function	0,58%	-.10	-.078					.25**	.21	-.18*	-.16
Soc. avoidance	0,69%	-.14	-.10	.31**	.30			-.30**	-.25		
Financial	0,47%	-.25*	-.19					.24*	.20		
Benefits	0,84%					.15	.13	-.11	-.0,98	.28**	.26
Fam. suffering	0,20%	.11	.0,85			-.11	-.0,96	.13	.10		
Body image	0,19%	-.18	-.14	.12	.11					.14	.13
Relapse	0,11%			.29**	.27			.12	.10		

As a result, if one considers religious orientation, one can notice that *personal extrinsic religious orientation* mostly indicates a factor that contributes to the explanation of most life quality components.

For the second component, that of *extrinsic religious orientation*, i.e. social religious orientation, the influence that it exercises on life quality dimensions is much more reduced than in the case of the personal one.

The influence of *intrinsic religious orientation* does not represent, as one can notice, a very high share of life quality explanation results. Still, for the benefits that the patient perceives as being determined by the existence of the disease, intrinsic religious orientation explains this criterion, even if to a smaller extent.

From among the strategies of *religious coping*, *negative religious coping* contributes to the explanation of most of life quality dimensions, thus helping the explanation of half of these dimensions.

Positive religious coping is inversely proportional with most of life quality dimensions. Thus, its highest influence is on explaining financial problems.

Spiritual factors are part of life quality improvement in neoplastic patients

As a conclusion, following the analysis of the data obtained, one can notice, as expected, that the highest influence of spiritual factors can be found in the case of positive feelings, which, in specialised literature, are also associated to the state of well-being felt by the ill person, a state of well-being which in some questionnaires that measure the life quality of neoplastic patients is viewed as a dimension in itself. Consequently, one can state that persons with a rich spiritual life will have the tendency of perceiving the disease in a positive manner, generally feeling well, due to soul tranquillity, giving meaning to disease and living according to their faith.

Table 2. – Results obtained following the analysis of relapse, focusing on the influence of spiritual factors on life quality:

Predictor	Δ R ²	Peace		Sense		Faith	
		B	answer	B	answer	B	answer
Neg. feelings	13,4%	-.40**	-.35				
Positive feelings	24%	.44**	.39	.20**	.18	.23**	.21
Cog. problems	0,89%	-.30**	-.27				
Pain	10,1%	-.35**	-.31				
Tiredness	0,66%	-.29**	-.25				
Sexual function	0,37%	-.18*	-.16			-.14	-.13
Social avoidance	0,64%	-.27**	-.24	.13	.12	-.18*	-.16
Financial	0,83%	-.29**	-.25	.20*	.18		
Benefits	0,08%					.19*	.17
Fam. Suffering	0,41%	-.23*	-.20				
Body image	0,86%	-.32**	-.28				
Relapse	0,96%	-.35**	-.31				

Conclusions:

The share of religious factors in the results explaining life quality has a relatively low influence on explaining the life quality of oncologic patients in Romania. Thus, one can conclude that according to the cultural environment and the way in which religion is promoted and then perceived by the individual, one can discuss the impact that religion has on the individual's life. As opposed to the results of specialised literature that support the important role of religion and to which one refers as well, for Romanian population it has a reduced implication, but still it cannot be neglected. One can notice that there are several dimensions of life quality in whose case religion has a higher impact, bringing an additional explanation and these are: experiencing positive feelings, social avoidance, benefits and fear of relapse. Consequently, one can notice that religious factors are mainly involved in estimating the psychological and social dimension, something that is otherwise reasonable considering the sphere of influence of religious factors. Also, as one has anticipated, both coping religious and religious orientation are involved in explaining life quality.

As opposed to religious factors, spiritual factors have a significant share in improving the life quality of patients suffering from cancer, on the one hand, becoming a part of the explanation of most life quality dimensions, and on the other hand, their share of the results explaining them being much higher. Looking at these results, one can state that by their contribution to the appearance of positive feelings, by explaining their appearance to an overwhelming extent, spiritual factors contribute to increasing life quality. According to the data of specialised literature, one can also state that, following the results obtained at the level of Romanian population, experiencing a state of peace by having positive feelings both towards the disease, and towards life in general, the ill person will not suffer so intensely because of the disease; the pain diminishes, the tiredness is no longer felt, the fear that the disease can appear no longer has the same impact on one's feelings, the ill person accepting and living with the changes that appear regarding one's physical appearance, all these ways of relating to the new situation and to the disease determining the improvement of one's life quality.

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