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The Role of Religious Values in Coping with Cancer

MARVIN W. ACKLIN, EARL C. BROWN AND PAUL A. MAUGER

ABSTRACT: The relationship between transcendent meaning attribution, religious orientation, and psychological well-being was studied in cancer and noncancer patients to test the hypotheses that intrinsic religious values and life meaning enhance coping and well-being during the course of the life-threatening illness. Subjects were 44 patients receiving medical treatment for cancer and noncancer medical conditions. In the cancer group, higher levels of attributed life meaning were positively linked with intrinsic religious orientation, and associated with lower levels of despair, anger-hostility, and social isolation. Cancer patients scored higher than noncancer patients on depersonalization, suggesting the presence of psychic numbing in response to their illness. Noncancer group results were characterized by positive correlations betwen transcendent meaning, religious orientation, and denial, suggesting marked differences between the two groups in coping styles and salience of life meaning attribution. A rationale for the observed differences in coping styles between the two groups is presented, highlighting perceived life threat as a key differentiating variable.

Introduction

An informal but persistent notion current in the lore of thanatology and existential philosophy states that confrontation with the fact of one's own mortality provides a person the unique opportunity to reorganize life priorities, and to appropriate a more "authentic," perhaps religiously informed, approach to living.[1] For example, Ring writes that "to live in the shadow of death, as if each day might be our last, can clearly promote a quickening of one's spiritual sensitivity."[2] The human encounter with vulnerability and death, revealed through such life crises as war, natural disaster, and serious illness, it is said, provides a compelling necessity for persons to deal with larger questions of life, questions of "ultimate" concern and meaning.

Frankl emphasizes the unique and essential role of "meaning" in human motivation.[3] His phrase, "will to meaning," refers to a fundamental human impulse to appropriate a sense of inherent meaningfulness and purpose in living. Reflecting Frankl's point of view, Kotchen links meaning with existential

Marvin Acklin is a Doctoral Candidate in Clinical Psychology at Georgia State University, Atlanta, Georgia 30303. The work reported here was presented in partial fulfillment of the requirements for the Master of Arts degree in Psychology, Department of Psychology, Georgia State University, by the first author under the direction of the second and third authors. An abridged version of this paper was presented at the annual meeting of the American Psychological Association, Washington, D.C., August 25, 1982. Special thanks to Roger Bakeman, Ph.D., for his helpful suggestions.

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mental health when he writes that "a mind is healthy when it has achieved a sufficient store of 'meaning' to enable it to master suffering and to direct daily action."[4] By "meaning" is meant the capacity to construe and understand life experiences within a broad context of religio-cultural symbols, values, and possibilities.

Clinically, it has been observed that persons experiencing terminal illnesses and near-death experiences gain a peculiar transcendent "overview" of their life.[5] This transcendental life perspective is often spoken of as a powerful, healing experience. As a process of "self-completion," as Lifton terms it, it is an extension of one's life involvements and connections beyond the self "to collective modes of symbolic immortality."[6] The process of experiential transcendence, as a shift of meaning from an ego-centered to a generally human system of references, stands in contrast to personal, "everyday" meanings: the commonly held and, for the most part, unconsciously understood assumptions about daily life in the world.

Traditions of religious belief and practice have functioned as important sources for the values, meanings, and images people turn to in their search for answers to questions concerning human vulnerability and destiny. Religious belief systems, or religio-cultural *mythoi,* function to orient existence broadly, integrating the person and his or her community within an overarching, interrelated framework of meaning which is interpretive of the good life, human fallibility and vulnerability, death, and personal destiny. Religious belief systems, in short, function to provide a medium of meanings within which the individual's life experiences may be illuminated, integrated, and understood.

Gordon Allport's work on religious orientation is directly relevant to the question of the role of religion in coping with life crisis. Allport conceptualized an extrinsic-intrinsic typology in religious orientation to account for the fundamental differences he observed in religious belief and motivation. In Allport's conceptualization, an extrinsic orientation to religious belief and practice is instrumental to other high-order personal and social ends. Intrinsic religious orientation, on the other hand, focuses on religious belief and practice, ends in themselves. In the oft-quoted comment, Allport and Ross write, ". . . the extrinsically motivated person *uses* his religion, whereas the intrinsically motivated person *lives* his religion."[7] Linking intrinsic religious orientation to mental health, Allport had earlier predicted that "mental health will vary according to the degree to which adherents of any faith are intrinsic in their interpretation and living of their faith."[8] Other investigators have suggested that Allport's intrinsic and extrinsic dimensions actually represent pervasive personality variables reflecting, respectively, open and closed cognitive-perceptual styles, and are not limited to the domain of religious belief and practice.[9]

This study was concerned with the role played by religious orientation, transcendent meaning attribution, and church attendance on psychological well-being in those persons for whom questions of vulnerability and mortality are thought to be most pressing, namely, the seriously and terminally ill. Of particular interest was the religious and coping experience of the person with cancer. There is a general public perception of cancer as tantamount to a death

sentence. Laden with the imagery of mysterious provenance, decay, and inevitable fatality, its impact and implications exceed those of other chronic illnesses, some of which have a more serious prognosis. Five questions were of special interest for this investigation:

1. Given the variables of religious orientation, transcendent meaning attribution, and psychological well-being, what differences in coping may be observed in comparing life-threatening medical conditions (cancer) with non-life-threatening medical illnesses?
2. Is there, as has been theorized, a relationship between intrinsic religious orientation and the meaning dimension of religious belief?
3. What role do intrinsic religious orientation and church affiliation play in coping with serious or life-threatening illnesses?
4. Does the ability to construe illness experience from a transcendent meaning perspective enhance psychological well-being in serious illness?
5. Are there differences between cancer and non-life-threatening illnesses in the role and salience of transcendent meaning?

Method

Subjects. Subjects for this study were 44 adult patients receiving medical treatment for cancer (N = 26) and noncancer conditions (N = 18) at Georgia Baptist Medical Center, Atlanta, Georgia. Basic criteria for inclusion were recent diagnosis or recurrence of cancer or other illness, a tenth-grade level of education, and voluntary consent to participate.

The cancer group consisted of 20 females and 6 males, was predominately outpatient (20 outpatients, 6 inpatients), with ages ranging from 20 to 76 and a mean age of 48. Mean level of education was 11.2 years. Diagnoses included Hodgkin's Disease, leukemia, lymphoma, colon, lung, and oat cell carcinoma. Cancer subjects attended church an average of 3.3. times per month.

Noncancer subjects were predominately female (12 females, 6 males), all inpatient, with ages ranging from 18 to 61 with a mean age of 42. Mean level of education for noncancer subjects was 13.7 years. Noncancer subjects were receiving medical treatment for acute and chronic conditions that were nonmalignant and judged by attending physicians to be non-life-threatening. These included coronary obstruction, renal stones, gall bladder and liver surgery, hemorrhoidectomy, and rectal fissure. Noncancer subjects attended church 5.6 times per month.

Instruments. Subjects were asked to complete a series of questionnaires. First, standard demographic questions were asked about gender, level of education, age, diagnosis, length of diagnosis, and weekly rate of church attendance. Second, the Life Meaning Scale, a 72-item Likert type of survey, was composed by the first author for this study to assess transcendent meaning attribution. The scale is composed of declarative statements that construe possible interpretations in descriptive and religious/symbolic terms of the person's illness as a life event. The statements in the scale were pooled from actual comments made by hospital patients experiencing serious and terminal illnesses, and gathered over several years of clinical experience. Examples of survey statements include: "I feel completely hopeless," and, "I feel a new sense of spiritual wholeness now." The Life Meaning Scale yields a total score for attributed transcendent meaning, ranging from 72 (most pessimistic) to 355 (most op-

timistic). This study was the first attempt to validate the Life Meaning Scale. Third, the Allport-Ross Religious Orientation Scale was used to measure orientation to religious belief and practice. This extensively validated 21-item Likert type of survey yielded subscale scores for intrinsic and extrinsic religiosity. Fourth, six subscale scores were selected from the Grief Experience Inventory[10] for use as measures of coping and psychological well-being. Subscales from the 61-item true-false survey were chosen to tap relevant dimensions of coping and well-being in an illness situation. The survey yielded subscale scores for denial (DEN indicating a hesitancy to admit to common but socially desirable weaknesses and feelings, used as a questionnaire social undesirability scale); despair (DES measuring level of irritation, anger, and feelings of injustice); social isolation (SI measuring withdrawal from social contacts and responsibilities); depersonalization (DEP measuring numbness, shock, and confusion); and death anxiety (DA measuring intensity of personal death awareness). The Grief Experience Inventory subscales were originally standardized on reference groups of adults experiencing recent bereavement. Validity and reliability data for the scales are presented in the Inventory manual.[11]

Results. Results of tests of significance for all predictor and coping variables between cancer and noncancer groups are presented in Table 1. The sole notable difference between the two groups is found for the psychological well-being measure of depersonalization, cancer subjects scoring significantly higher on this variable.

Intercorrelational matrices for predictor variables—transcendent meaning attribution, intrinsic and extrinsic religious orientation, and church attendance—for cancer and noncancer groups are presented in Table 2.

Intercorrelational matrices illustrating internal relationships between measures of psychological well-being are presented in Table 3.

Finally, correlational data for predictor variables and measures of coping and psychological well-being for both groups are presented in Table 4.

Discussion

While limitations of sample size and constituency necessarily limit the generality of our findings, results of this investigation provide support for the assertion that transcendent meaning, religiosity, and church attendance play positive roles in coping and well-being in life-threatening illness.

Research Question 1. While cancer is commonly thought of as an extremely stressful, psychologically devastating illness, our findings do not support the notion that the cancer patients are coping any worse than their noncancer counterparts. The findings do shed light, however, on differences in coping styles between cancer and noncancer subjects. The significant mean difference in depersonalization between the two groups suggests that cancer subjects blunt their emotional awareness as a means of handling the painful reality of a chronic, progressive, and potentially lethal illness. Cancer subjects do not actually deny their medical condition on an intellectual level. Rather, they report a kind of self-distancing or "psychic numbing,"[12] feeling that "this can't really be happening to me," and, "I seem to be watching myself go through the motions of living."

Alexander and Alderstein describe a similar phenomenon in their study of death attitudes in religious students:

Table 1

Mean Scores for Cancer and Noncancer Groups

Variable	Cancer	Noncancer	t-score
A. Predictor			
Transcendent Meaning	287.5	298.	-1.34
Intrinsic Religious Orientation	32.2	35.0	-1.21
Extrinsic Religious Orientation	39.2	42.7	-1.33
Church Attendance	3.3	5.6	-1.64
B. Psychological Well-Being			
Denial	46.7	41.9	1.32
Despair	47.3	43.1	1.14
Anger-Hostility	41.8	40.8	0.22
Social Isolation	46.9	44.0	1.11
Depersonalization	47.9	38.2	3.61***
Death Anxiety	47.6	44.39	0.80

***$p < .001$

Table 2

Intercorrelations for Predictor Variables

	TM	IRO	ERO	ChA
A. Cancer Group				
Transcendent Meaning (TM)	--	.41*	.22	.34*
Intrinsic Religious Orientation (IRO)		--	-.11	.52*
Extrinsic Religious Orientation (ERO)			--	.07
Church Attendance (ChA)				--
B. Noncancer Group	TM	IRO	ERO	ChA
Transcendent Meaning (TM)	--	.72***	.35*	.40*
Intrinsic Religious Orientation (IRO)		--	.41*	.42*
Extrinsic Religious Orientation (ERO)			--	.55**
Church Attendance (ChA)				--

*$p < .05$
**$p < .01$
***$p < .001$

Table 3

Intercorrelations for Measures of

Psychological Well-Being

A. Cancer Group

	DEN	DES	AH	SI	DEP	DA
Denial (DEN)	--	.18	.14	.12	-.43**	.03
Despair (DES)		--	.77***	.82***	.29	.46**
Anger-Hostility (AH)			--	.68***	.26	.42*
Social Isolation (SI)				--	.18	.24
Depersonal-ization (DEP)					--	.16
Death Anxiety (DA)						--

B. Noncancer Group

	DEN	DES	AH	SI	DEP	DA
Denial (DEN)	--	-.28	-.34	-.44*	-.32	-.25
Despair (DES)		--	.61**	.61**	.55**	.28
Anger-Hostility (AH)			--	.74***	.57**	.48*
Social Isolation (SI)				--	.39*	.46
Depersonal-ization (DEP)					--	.46*
Death Anxiety (DA)						--

*$p < .05$
**$p < .01$
***$p < .001$

Table 4

Correlations between Predictor Variables and Measures of Psychological Well-Being

A. Cancer Group	DEN	DES	AH	SI	DEP	DA
Transcendent Meaning	-.11	-.57***	-.50**	-.60***	-.12	-.16
Intrinsic Religious Orientation	-.01	-.19	-.34*	-.28	-.20	-.15
Extrinsic Religious Orientation	.25	.01	-.11	-.18	-.15	-.02
Church Attendance	-.07	-.29	-.39*	-.32*	-.23	-.10
B. Noncancer Group						
	DEN	DES	AH	SI	DEP	DA
Transcendent Meaning	.58*	-.23	-.16	-.26	-.13	-.05
Intrinsic Religious Orientation	.52*	-.31	-.26	-.28	-.22	.09
Extrinsic Religious Orientation	.37	-.36	-.23	-.24	-.48*	-.36
Church Attendance	.14	-.36	-.50*	-.40*	-.10	-.32

*$p < .05$
**$p < .01$
***$p < .0001$

In probing the personal aspects of dying . . . the typical response pattern might be described as one of displacement of focus. It is as though that which is negative in the field is made peripheral and that which is tolerable is made central.[13]

Weisman also reports a similar phenomenon in his study of terminally ill cancer patients which appears to resemble the depersonalization reported by our cancer patients.[14] Weisman's term for this psychic numbing is "middle knowledge," i.e., a fluctuating midpoint in the equilibrium between repudiation and acceptance of the individual's life circumstances.

Research Question 2. The theoretical assertion that intrinsic religious orientation is conceptually related to the meaning dimension of religious belief, rather than to a merely formalized, that is, extrinsic, response, finds support here. Moderate to high positive correlations (See Table 2) in both groups suggest that intrinsic religious orientation and transcendent meaning are related constructs.

In the noncancer group, the fact that extrinsic religious orientation is positively associated with both transcendent meaning ($r = .35, p. < .05$) and intrinsic religious orientation ($r = .41, p < .05$) is a puzzling and unexpected finding. While it is true that extrinsic religious orientation is associated with transcendent meaning, the association between intrinsic religious orientation and meaning is significantly greater than the relation between meaning and extrinsic religiosity, $t\,(15) = 4.15\, p. < .01$.

Two interesting questions emerge upon examination of the noncancer group data. The noncancer group presents a moderately strong positive association between intrinsic and extrinsic religious orientation ($r = .41$). Empirical studies have found that these two "types" of religious orientation are independent of each other (cf. the cancer group's correlation coefficient of $r = .11$), rather than bipolar variables. Thus, the positive association found here is rather unusual. Further, the noncancer group shows a positive association between transcendent meaning attribution and extrinsic religious orientation ($r = .35$). This is likewise an unexpected finding, as we might expect these two variables to be conceptually unrelated. These findings make somewhat better sense in light of the noncancer patient's overall self-presentation in a more socially acceptable (compare the positive relations between both meaning and intrinsic religious orientation, and denial in this group: Table 4) and, hence, in a more conventionally pious or pro-religious light. This brings to mind Allport's designation of such persons as "indiscriminately pro-religious,"[15] and may point to the presence of social desirability in those persons for whom the stakes are not high, that is, who are not facing a life-threatening medical condition. These differences in self-disclosure, as a possible function of perceived life threat, will be discussed further below.

Research Question 3. Based on our findings, intrinsic religious orientation *per se* does not appear to play a significant role in supporting coping and well-being during serious illness. Higher frequency of church attendance, however, is associated with decreased feelings of anger-hostility and social isolation. This was so in both groups (Table 4). There is some evidence to suggest that church-going people in general may be more restrained in the expression of aggressive affects.[16] It may be, however, that a patient receiving medical

treatment can ill afford to express hostile affects, especially toward those upon whom the patient is dependent for care and treatment.

Frequency of church attendance, for both groups of subjects, is also associated with decreased feelings of withdrawal and isolation. This finding supports the as yet empirically unsubstantiated impression that church-going persons cope better in the crisis of serious/terminal illness.[17] Unfortunately, data for the presence of family support or other affiliations (e.g., voluntary associations) were not collected for this study. It appears that church may provide a system of support and affiliation, mitigating a fear frequently expressed by the seriously ill and dying: the dread of isolation and abandonment.[18]

Research Questions 4 and 5. Our findings do not suggest that people who are able to construe their illness situations meaningfully cope comparatively better than those who do not understand their predicament meaningfully. Significant differences between illness groups for transcendent meaning attribution and measures of psychological well-being (with the exception of elevated depersonalization scores in the cancer group) were not found. For cancer subjects, however, negative relationships between transcendent meaning attribution and scores for despair, anger-hostility, and social isolation indicate that life meaning is closely associated with coping efforts and psychological well-being.

An interesting contrast between the two groups emerges in regard to self-disclosure of religiosity and meaning attribution. The cluster of significant positive correlations between transcendent meaning attribution, intrinsic religious orientation, and denial in the *noncancer* group highlights a fundamental difference in coping styles between cancer and noncancer subjects. Religious belief and transcendent meaning appear to function differently, that is, have a different salience, for persons who have received assurance that their medical condition is not potentially lethal. In the absence of the threat of a lethal outcome, noncancer subjects in effect have the implicit assurance of continued life within an "everyday" horizon of values, possibilities, and social expectations, including self-disclosure on our research questionnaires. Patients with a life-threatening illness, who are able to view their life situations from a perspective of transcendent meaning, may "pretend" less in their self-disclosure. The level of life threat appears to be an important differentiating variable in whether a process toward an integration of transcendence occurs, that is, the movement and understanding of one's life situation from the perspective of a sustaining, encompassing context of life meaning.

Our cancer group findings support the traditional assertion that confrontation with the possibility of one's own death precipitates a search for meaning and a "summing" or integration of one's life experience. While psychic numbing may never be entirely absent, experiencing one's life story within a context of religious images and possibilities, as a sort of self-completion, appears to play an instrumental role in coping with the uncertainties of life-threatening illness.

The results of this study have implications for pastoral practice and intervention with the seriously and terminally ill. Both the objective-medical

and the individual's subjective levels of perceived life threat are important discriminating factors in therapeutic approach with the person in crisis. For example, persons suffering from myocardial infarction have been found to benefit psychologically from denial, although incurable cancer patients could not.[19] There is further evidence to suggest that patients who avoided or denied information about a forthcoming elective surgical operation ("avoidant" types) showed faster recovery and less distress than patients who sought information about their operations ("vigilant types").[20] Thus the helping person may support such "positive denial" in the service of coping with the person experiencing a non-life-threatening illness, for example, in the case of the pre- or post-operative surgical patient. On the other hand, with the individual experiencing a life-threatening or terminal illness, given indications that he or she is amenable, one may assist in the process of life-review, integration, and self-completion. Allport wrote that religion is a person's "ultimate attempt to enlarge and to complete his [or her] own personality by finding the ultimate context in whch he [or she] rightly belongs."[21] Using the individual's medium of religious values, meanings, and images, the helping person can support and facilitate the patient in developing broader, sustaining felt connections with larger horizons of life beyond the self.

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