The Association between Quality of Life and Religious Coping in Lung Cancer Patients: A Qualitative Case Study

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Abstract

Lung cancer is a type of cancer that is difficult to cure, yet the number of lung cancer patients continues to increase every year. Due to the difficulty of fully recovering from lung cancer, patients need an effective coping strategy to help them maintain their quality of life. The present research is a qualitative case study aimed to determine the linkage between religious coping and quality of life among lung cancer patients. The subjects consisted of 5 lung cancer patients who were undergoing lung cancer treatment at a Bandung regional hospital specializing in lung and respiratory diseases. Data was obtained through questionnaires and interview. The questionnaires consisted of the WHOQOL-BREF to measure the degree of quality of life and the BRIEF RCOPE to assess the type of religious coping used. The results showed a link between quality of life and religious coping in several participants. The relationship between the two variables depended on an individual’s value toward God and their comprehension of religion as an aid that helps them manage their pain, their commitment to God and religion, as well as the style of religious coping used to solve their problem. The results of this research can potentially be used by hospitals, families, and caregivers to help patients improve their quality of life while dealing with cancer and its effects.

Keywords—Lung cancer, quality of life, religious coping

1. Introduction

According to data from Basic Research of Well-being (Riskesdas) in 2008, cancer was the 7th leading cause of death in Indonesia, accounting for 5.7% of total deaths. The data also showed that the prevalence of cancer in Indonesia is at 4.3 per 1000 people. Another national research conducted in 2010 showed that cancer was the 5th leading cause of death in Indonesia, suggesting an increase in the trend of death caused by cancer between 2008 and 2010. In 2012, WHO reported that out of 5 types of cancer, lung cancer caused the highest number of deaths (1.4 million deaths). Additionally, a 5-year survival rate for a lung cancer patient is only 13%, which is much lower than the survival rate for breast cancer, prostate cancer, and colon cancer, which can be as high as 80%.

With such a low possibility for long time survival, lung cancer patients are thus more susceptible to severe distress compared to other cancer patients. Distress linked with quality of life or physical and mental health is related to how people deal with stress (Lazarus & Folkman, 1984). WHO defines quality of life as one's perception of his position, which is associated with cultural and personal values as well as with a person’s objectives, standards, and expectations of life. Quality of life is considered a broad concept that is influenced by the physical and mental condition of the individual, level of independence, the quality of social relationship, personal beliefs, and their relationships to salient features of environment (WHOQOL, 1998). Loss of physical function, having psychological conditions such as depression, and the decline in the overall quality of life in cancer patients are correlated with symptoms of the disease, which are uncontrollable (Gridelli et al., 2001; Montazeri, 1996).

Consequently, lung cancer patients need a coping strategy that can help them achieve a better quality of life. Lung cancer is difficult to cure with little chance of total recovery; hence the possible problem-focused coping is no longer effective. Therefore, emotion-focused coping is needed so that lung cancer patients can achieve a better quality of life and experience the positive impact of improving their quality of life. People tend to use problem-focused coping when dealing with work-related matters, such as taking direct action or seeking help from others, while emotion-focused coping is more frequently used when dealing with health problems because health
threats often must be tolerated but may not be amenable to direct action (Taylor, 2012).

There are various types of emotion-focused coping that can be used to regulate emotions. One of them is by involving God and religion. Sherman and Simonton (2001) found that religious activity is a coping response that is often performed by cancer patients. There are several benefits from involving religion, such as a reduction in the stress experienced by cancer patients, the feeling of remaining in control, the maintenance of hope, self-esteem, and the meaning and purpose of life, as well as the availability of social support from religious communities (Coward, 1995; Levin, 1996; Moadel et al., 1999; Taylor, 2012).

Past research has stated that religious coping plays an essential role in the quality of life of cancer patients, and that the type of religious coping used will determine whether the individual's quality of life improves or worsens (Tarakeshwar et al., 2006). Pargament (1998) classified religious coping into two types: positive and negative, whereby the use of positive religious coping may generally provide benefits for people facing a stressful event (Ano & Vasconcelles, 2005; Koenig et al., 2001). Conversely, the use of negative religious coping is believed to cause maladaptive effects (Ano & Vasconcelles, 2005; Exline & Rose, 2005). A study conducted by Brelsford et al. (2015) showed that the use of negative religious coping under stressful conditions is still more prevalent compared to the use of positive religious coping. Additionally, using negative religious coping is linked with undesirable outcomes, while using positive religious coping can lead to better outcomes.

The prevalence of the use of religious coping among patients depends on the type of stressor, patient characteristics, and situational factors (e.g., the type of disease, time since diagnosis, stage of disease, remission status, and treatment) (Spilka, Shaver, & Kirkpatrick, 1985). For lung cancer patients, lung cancer not only functions as a stressor for the patient, but also carries with it the risks of a type of disease that causes the highest mortality rate among other types of cancer. In addition, lung cancer patients only have a small chance to recover and often need aggressive treatments such as chemotherapy, radiation therapy, and/or surgical removal of the lobes of the lungs, all of which have their side effects. Based on the above explanations, the researcher of the current study expected to see a high prevalence of religious coping among lung cancer patients. As it can be inferred from previous research that religious coping is positively associated with quality of life, it is also important to determine the effectiveness of religious coping in maintaining the quality of life of lung cancer patients, especially considering that lung cancer is difficult to cure.

2. Materials and Methods

The research design used in the current study is a mixed method with a case study approach. The researcher conducted in-depth interviews with lung cancer patients, then used a concurrent triangulation strategy wherein the researcher collected both quantitative and qualitative data simultaneously and then used the data to see combinations that occurred (Creswell, 2008). The method is aimed to obtain more thorough data as well as to counteract the weaknesses of a single method with the strengths of a different method. In the present study, quantitative data was taken to determine the degree of quality of life and the type of religious coping used, while the qualitative data was used to reveal the dynamics that affect the subjects’ quality of life and the reason subjects used a certain type of religious coping.

A nonprobability sampling approach, more particularly a purposive sampling technique (Cozby, 2009), was used in the current study. Patients who matched the research criteria were chosen as research subjects. A total of 5 people was used in the sample, all of which matched the following criteria: having lung cancer as their main illness, currently undergoing medical treatment, having been formally diagnosed, and willing to participate in the research. Data were taken using questionnaires and semi-structured interviews. The questionnaire used to determine the degree of quality of life was WHOQOL-BREF, while the questionnaire used to assess the type of religious coping was BRIEF-RCOPE. WHOQOL-BREF has been translated into various languages, one of which is Indonesian. The Indonesian version has been tested for its reliability on samples of elderly patients (Kusumaratna & Hidayat, 2009), breast cancer patients (Iskandarsyah et al., 2013), and cervical cancer patients with Cronbach's Alpha .949 (Kasdi, 2015). Similarly, BRIEF RCOPE yielded a reliability score of .776 (Paramita, 2012). In Indonesia, BRIEF RCOPE was shown to have high internal consistency (Ginting, 2011).

The interview contained several questions about the environmental characteristics surrounding the research participants that might affect their quality of life, participants’ use of religious coping, and participants’ thoughts and feelings across three separate instances: 1) when they were first diagnosed, 2) while undergoing treatment, and 3) during data collection. Additionally, their thoughts and feelings about the future were also asked. The questions were designed to obtain a more comprehensive picture of the reason the research subjects chose a specific type of religious coping and why they experienced a certain degree of quality of life.

3. Result and Discussion

The results revealed that all subjects used a positive religious coping style, though they did so with varying degrees. 3 subjects, namely R, N, and A, used a high level of positive religious coping, while subjects D and S used positive religious coping to a lower extent. Table 1 shows the scores for each investigated category. The scores were transformed such that the score for each category has equal weight, despite having different numbers of questions. In terms of quality of life, patient A demonstrated a relatively poor quality of life compared to the other four other patients, who all tended to have a
good quality of life. Judging from the scores per dimension, it can be seen that subject A scored the lowest on psychological and environmental dimensions. A’s qualitative data showed that the patient often had negative feelings that involve anxiety resulting from his financial difficulties. The patient felt helpless and confused regarding how to fulfill his family’s financial needs while he was undergoing treatment, as the treatment weakened his physical condition and made it impossible for him to work. Basing quality of life on the comparison between an individual’s current condition and their desirable condition, it can be said that the A’s financial situation is the reason for his lower quality of life.

Analyses of both qualitative and quantitative data on religious coping and quality of life and its dimensions revealed a linkage between religious coping and particular dimensions of quality of life. Such a relationship could have arisen from various factors that could affect quality of life, such as particular areas in an individual’s life that are prominent for him or her. For some people, religion may not play an especially important role in transforming their life, and as such, patients with lower religious coping scores yet better quality of life might have utilized other coping mechanisms they deem more effective than religion or the presence of God.

A. Linkage between religious coping and physical health dimension

On the physical health dimension, subject’s N and AS had high scores despite their lower scores on religious coping, this could be explained by considering other factors, such as current physical condition, which could affect how people perceive their overall physical health. At the time of data collection, N and AS had nearly completed their treatments, had good physical condition, and had been declared almost recovered by doctors.

B. Linkage between religious coping and psychological dimension

With regard to its psychological effects, religious coping functions to give meaning, control, comfort, and intimacy, as well as to trigger the kind of life transformation that can help subjects enhance their psychological condition. The controlling function of religious coping was demonstrated by subject’s R and N, who often attempted to cope with dhikr (a form of Islamic prayer) during times when they had to control the pain that could not be overcome by drugs. For them, performing dhikr was not only effective for managing pain, but also for calming themselves down, which in turn reflects the comforting function of religious coping. Moreover, especially relevant to the role of religious coping in giving life meaning is the subjects’ claim that they did not consider lung cancer as God’s punishment for them, despite their widespread agreement that lung cancer was a negative event that changed their lives, the subjects also did not believe that lung cancer could be attributed to witchcraft, instead stating that God and their religion had the power to heal them and would always love them. Such beliefs seemed to help the subjects build a positive perspective on life, mainly with regard to their recovery and future.

C. Linkage between religious coping and social relationship dimension

In the social dimension, all subjects' scores could be categorized as moderately good. Subjects were satisfied with the support provided by their friends and family, which therefore positively affected their adherence to treatment. As mentioned earlier, one of the functions of religious coping is to provide intimacy, whereby people perceive that their religious organization or place of worship would help them overcome negative events.

Subjects DI and R both felt they received help from their religious organization and believed it helped them
recover. Meanwhile, subject’s N and AS said they did not receive support from religious organizations but did not consider it a problem that would otherwise affect their quality of life, especially since quality of life is an individual assessment that depends on each person’s subjective values. Woodill et al. (1994, in Rapley, 2003) mentioned that quality of life depends on people’s satisfaction towards fulfillment of their needs. Subjects N and AS probably did not perceive support from religious organizations as an important aspect of their lives, and thus lack of such support did not influence their quality of life. In contrast, for DI and R, support from religious organizations was probably held at a higher value, such that it positively influenced them in a way that made both subjects feel some improvement in their condition after receiving said support.

D. Linkage between religious coping and environmental dimension

Within the environmental dimension, only one subject (subject A) perceived his condition as moderately bad, while the other four subjects tended to perceive their environment as good. Viewed from the qualitative and quantitative data collected, A’s negative perception seemed to have stemmed from his dissatisfaction with his financial situation, which he considered a prominent area in his life.

Although A admitted to having frequently sought help from God and to having faith in God’s power, he still felt the lack of a significant change in both his financial and physical conditions. In his interview, subject A was found to constantly focus on the fact that he was economically poor, yet he believed that his financial difficulty could not be solved by simply accepting the condition. A also did not believe that his financial problem could be solved merely by regulating his emotions, and instead would be better solved through the direct action that is required in problem-focused coping. Theoretically, a financial problem such as that experienced by A would indeed be easier to solve using problem-focused coping instead of emotion-focused coping (Zakowski, Hall, Klein, & Baum, 2001, in Taylor, 2012). On the other hand, as mentioned in the outset, religious coping as a form of emotion-based coping should be more effective for dealing with one’s health problems. Yet A felt his religious coping activities did not significantly impact his quality of life. It is important to note, however, that religious coping should provide more benefit if people surrender to the belief that some problems are beyond their control and cannot be solved except by God’s ability (Krause, 1998; Wink & Dillon, 2001; Pargament, 2002). Perhaps the reason subject A did not experience the maximum advantage of religious coping is because despite his high religious coping score, he lacked the faith that his problem could be solved with religious coping.

4. Conclusion

Based on the analysis and discussion of the results obtained from the 5 subjects of the study, it could be inferred that in general, a relationship exists between religious coping and quality of life. The strength of such a relationship is especially apparent in the psychological dimension, in which religious coping was able to make subjects feel calmer and help them control the pain caused by their disease or the treatment they had to undergo. The quality of life of four subjects were categorized as moderately good, while one other subject had a moderately poor quality of life. The subjects’ quality of life was influenced by various factors, such as their current physical condition compared to before their lung cancer diagnosis, their psychological response to lung cancer, the support they received during treatment, and access to quality health service.

For some subjects, a link between the use of religious coping and their assessment of quality of life was found. The relationship between religious coping and quality of life depended on subjects’ valuation of the importance of religion and God as the source of their pain relief. Another factor that could alter the impact of religious coping on quality of life was subjects’ commitment towards religion and God.

Several limitations of the current study, along with some suggestions on how to potentially overcome them in future research, are listed below:

1. Inquiry about subject's religiosity and the role of religion in subject’s life may prove noteworthy, as these components of a subject's life may affect subject's tendency to use religious coping to deal with problems

2. In the present study, the researcher only obtained data from questionnaires and subject interviews, without acquiring additional data about changes in subjects' condition (i.e., at the time of diagnosis, during treatment, and at the time of data collection) from medical records and interviews of people significant to the patients' lives. Additional, more objective data might have been necessary to paint a more accurate picture of subjects' conditions, especially as the adverse physical and psychological effects of treatment might have made it difficult for some subjects to share their experiences and current situation. Additionally, due to the dynamic nature of religious coping, it may be important to determine whether subjects use religious coping from the beginning, when they first discovered they had lung cancer.

3. In the future, researchers can simplify the questions included in the questionnaire, structuring them in the kind of language that is easier for subjects to understand.

4. To uncover more specific details about the role of religious coping in quality of life, future researchers can also collect data on subjects’ pre-existing quality of life prior to their use of religious coping strategies.

5. Future research can involve a larger sample, which would enable the use of quantitative statistical techniques to see the degree of correlation between religious coping and quality of life.
References


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