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Culture, Religion and Spirituality in Coping

The Example of Cancer Patients in Sweden

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Abstract
Recent research has shown significant associations (negative and positive) between religious and spiritual factors and mental health. Much of this research, however, has been conducted in the US, where religion is an integrated part of most people's lives. Other studies on religious and spiritually oriented coping conducted outside the US have also focused on religious people. Yet many are non-believers, and many believers do not consider themselves religious, i.e. religion is not an important part of their life. There are also societies in which the dominant culture and ways of thinking dismiss the role of religion in people's lives. Research on religious coping rarely takes these people into consideration. This book is based on a research project aimed at identifying the religious and spiritually oriented coping methods used by cancer patients in Sweden as an example of societies where religion is not an integrated part of the social life of individuals. The empirical data for the study were based on interviews with cancer patients. Fifty-one interviews were conducted in various parts of Sweden with patients suffering from different types of cancer. The chosen method was semi-structured interviews. Based on the study, the book discusses the impact of rationalism, individualism, secularism, natural romanticism and a tendency toward spirituality rather than religiosity in Swedish ways of thinking on the choice of coping methods among informants. Concerning the use of religious and spiritually oriented methods by the Swedish informants, we learn that gaining control over the situation is a very important coping strategy among Swedish informants. The informants show a strong tendency toward relying primarily on themselves for solving problems related to their disease. Receiving help from other sources, among others God or a supreme power, seems to primarily be a way to gain more power to help oneself, as opposed to passively waiting for a miracle. For the informants, thinking about spiritual matters and spiritual connection seems to be more important than participating in religious rituals and activities. Turning to nature as a sacred and available resource is a coping method that all informants have used, regardless of their outlook on God, their religion and philosophy of life or their age and gender.

Key words: religion, spirituality, coping, coping styles, coping methods, cultural perspective in coping

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To my dear friend Behrooz

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Preface

It was a warm, beautiful afternoon in the summer of 2003. I was sitting in a sidewalk café at Stanford University and reading an article in Surviving, a journal published by Stanford University for cancer patients and their families. The writer of the article was Behrooz Ghamari, the then editor of the journal, himself a cancer patient. The article was about his illness. He got cancer while he was in prison. This is an unbelievably sad story of a 20-year-old man who wanted to change the world, but who found himself surrounded by the walls of a small cell with 30 other political prisoners. While the physical and psychological torture perpetrated by the enemy constantly tore at his young but weak body, cancer was eating at him from the inside.

While my tears spilled onto the paper, my thoughts went back to exactly 20 years ago, to the year 1983, when I stood by a window in a small hostel room in Madrid, my tears spilling onto the letter I had in my hands. The letter stated that Behrooz had got cancer in prison. His situation was very bad, and there was no hope that they would release him. At that time, one year had passed since Behrooz was arrested, and some months had passed since I left Iran illegally. Behrooz was one of my best friends. Although I knew he was in prison, he was my hope, my way of coping with the extremely difficult situation I found myself in. All my hope, my coping strategy for enduring the horrible situation after leaving my home, my family and after many of my friends, all young, had been executed, was that one day I would meet Behrooz and say to him, "We did it. They could not defeat us. We made it through hell". When I stood in that small hostel room in Madrid, I believed I would never see Behrooz again. While crying in silence so as not to wake up my little son, I said to myself, "He will die in prison of cancer. He will not be remembered as a hero". At that time, I was still politically active, and dying as a hero was something we activists wished for ourselves and for others. I had no idea then that, twenty years later, I would find other heroes, not among political activists, but among cancer patients.

Knowledge of Behrooz's illness emptied me of hope. I became severely depressed. I did not know life had more bad news for me, that my mother had passed away some months earlier, only 56 years old, and that my family had not informed me. Despite my unbearably hard situation before leaving Iran and for a period afterward, despite learning about my mother's death, and despite my many hard years in exile, I did survive, as did Behrooz. They let him go when he could neither walk nor do anything else. He was

dying. His family took his dying body to the US, and he was admitted as a cancer patient at Stanford Hospital, at Stanford University. After years of fighting with cancer, he became better and began to work for the journal Surviving. He was editor for a while and wrote some articles for the journal, among others the one I was reading.

When I stood in that small hostel room in Madrid and read the letter about Behrooz's illness, I could not know that, 20 years later, I would write a book on coping with cancer. I also could not know that the suffering Behrooz and I endured would be the hidden reason behind a research project on how people cope in difficult situations. I had no idea then that Behrooz's courage, his way of coping with cancer in prison and afterward in exile, would help me in those difficult moments when I felt I could no longer continue my research, when I felt totally exhausted and wanted to give up, when I became depressed, tired and sad after listening to 51 cancer patients' stories about their journeys to and from hell. In such situations, remembering Behrooz's suffering and courage helped me continue my job.

Behrooz did not become my hero as a political leader, as I had wished, but he did become my hero and maybe a hero for others by showing us that life can be tough and seem unbearable, but that we can handle it – that people can find their own way to survive, their own coping method, if they wish. For some being in prison helps, for others being in exile, for some love and for others their God or another power come into the picture when coping.

Behooz Ghamari received his PhD in sociology and continued his fight with his pen, this time not fighting against, but fighting for – for knowledge. He showed us that we can do it. So did my interviewees. Each of them is a hero, because each of them has gone through a difficult journey, full of pain and desperation – a journey that demands a great deal of courage. Some of them succeeded in defeating the enemy, some did not; some could cope successfully, some could not; but they are/were all heroes. Heroes are not those who die in war, but those who show us the way. They are heroes for me because they taught me and others around them how to live. They showed the way, which is to appreciate every moment of life. I not only owe my gratitude to them for my research, on the basis of which this book is written, but also for my rebirth. They made me, and others around them, better people. I sincerely thank all of them.

Acknowledgments

Part one
Structure of the Study, Theoretical
Framework, Methodology

Chapter 1: Introduction

Although there is a large body of literature examining how people cope with different serious illnesses, the existential and spiritual aspects have largely been neglected (Gall et al. 2000; Dein 1997). This lack of attention exists despite some suggestions that religious attitudes and beliefs as well as spiritual feelings may influence help-seeking behavior (Seeman et al. 2003; Gall et al. 2000; Pargament et al. 2000; Dein 1997) and suggestions that religion and spirituality may give rise to a sense of morality with regard to questions of health, which may be a source of support when dealing with the uncertainties of aging and illness (Levin & Schiller 1987; Poloma & Pendleton 1989; Kaldestad 1996). On the other hand, some studies (Baider & Sarell 1983; Weisman & Worden 1976) reveal a negative effect of religion on individuals' well-being. Such negative effects are many times alien to researchers and clinicians.

In recent years, researchers have found significant relations (both negative and positive) between religious and spiritual variables and mental health (Strízenec 2000; Loewnthal et al. 2000). As Pargament et al. (2000:520) mention, some researchers "have called for greater sensitivity to, and integration of religion and spirituality into assessment and counseling" (e.g., Richards & Bergin 1997; Shafranske 1996). Much of this research, however, has been conducted in the US, where religion is an integrated part of most individuals' lives. Studies on religious and spiritually oriented coping in other countries have also been mainly conducted among religious people (see, e.g., Torbjørnsen et al. 2000; Gall et al. 2000; Alma 1998). There are, however, many individuals who are either non-believers or who, if they are believers, do not consider themselves as religious people, i.e. religion is not an important part of their life. We also find societies in which the dominant culture and ways of thinking do not leave much scope for religion to play an important role in people's lives. This issue is rarely taken into consideration in the research area of religious coping. An important question to pose here is: What role do religion and spirituality play in coping when non-theists or non-religious people face difficult events? And what is the role of culture and ways of thinking in the choice of religious and spiritually oriented coping methods? To answer these questions, there is need for sociologically as well as clinically relevant theoretical frameworks to advance research in this area by focusing on the cultural perspective. This book attempts, within the framework of a sociological study, to meet such a need.

The various ways in which individuals cope with different illnesses has been a major topic of interest in health research in Sweden during recent decades. However, the role of religious and spiritually oriented coping methods has remained an unresearched issue in this country. One reason for this may lie in the fact that, for many scientists, religion and spirituality are not seen as relevant to the human condition. As Jekins and Pargament (1995:53) state "psychotherapeutic thinkers tend to dismiss religion as 'superstition' (Sarason 1993), and medicine has had a long history of antipathy towards religion (Levin & Vanderpool 1992)".

Yet, despite such antipathy on the part of scientific research toward religion and spirituality, especially in the field of socio-medicine, attempts have been made by social scientists in some countries to integrate religious and spiritual phenomena within mainstream theoretical perspectives (e.g., Atchley 1997; Jenkins & Pargament 1995; Coleman 1992; Ellison 1991). Despite the importance of such studies on religious and spiritually oriented coping with different diseases, I have not found any research on this topic in Sweden (Ahmadi Lewin 2001a). To address this problem, and to redirect attention to the importance of cultural approaches in the research area of religious coping, I have studied religious and spiritually oriented coping strategies among cancer patients in Sweden.

This study will hopefully lead to a clearer understanding of the roles religion and spirituality play in the coping process. In addition, this study may help us better understand the needs and challenges faced by ailing people and provide creative ideas as to how their psychological well-being may be enhanced.

Aim of the Study

This book, which proceeds from a cultural approach to coping and health, is based on a research project aimed at identifying the religious and spiritually oriented coping methods used by cancer patients in Sweden. The empirical data for the present study are based on interviews with cancer patients.

Obviously, this was an enormous subject for a limited project, especially if the differences between religions were to be taken into account. The focus, therefore, was put on patients who had been socialized in cultural settings in which Christianity has been dominant. For this reason, Swedes socialized in a Jewish, Muslim or other non-Christian culture were not included in this study. This does not imply, however, that only those practicing Christianity were eligible. The exclusion concerned only people who had been reared in non-Christian religions. It should be mentioned that, whenever it is used, the term *Swedes* means people who have been socialized in the Swedish culture and have internalized the norms and values of Swedish society.

Fifty-one interviews were conducted in various parts of Sweden with patients suffering from different types of cancer. The chosen method was semi-structured interviews.

Guided by the aim of the study and a literature review, the following questions emerged as the basis of my investigation:

- What kinds of religious and spiritually oriented coping methods have cancer patients used?
- Which of the religious and spiritually oriented coping methods used by cancer patients can be categorized as religious coping as defined by the Many Religious Coping Methods (RCOPE)[1]?
- Besides RCOPE methods, what new religious and spiritually oriented coping methods have cancer patients used?
- What has been the role of culture in the choice of religious and spiritually oriented coping methods?

Overview

The book is divided into nine chapters:

Chapter 1 includes, besides an introduction, the aim of the study and overview of the book.

Chapter 2 discusses the theoretical framework of the study, addressing religious and spiritually oriented coping in a general perspective, with emphasis on factors of particular importance here. Also presented are the Many Methods of Religious Coping (RCOPE) and how I have used aspects of previous research in this area.

Chapter 3 explores how spirituality and religiosity may be defined. After discussing a range of definitions, I suggest my own working definition for the purpose of this study.

Chapter 4 explains the *raison d´être* of this research, i.e. why an investigation of religious and spiritually oriented coping methods based on a cultural perspective is necessary in the research field of coping. In this respect, the characteristics of religiosity and spirituality in Sweden will be focused on.

Chapter 5 explains the methodology.

Chapter 6 presents and analyzes, in the framework of a cultural approach, findings on some well-known assumptions about religious coping and the religious coping methods (RCOPE).

Chapter 7 presents and analyzes, in the framework of a cultural approach, the religious and spiritually oriented coping methods, which are new and not listed in RCOPE.

Chapter 8 includes a short overview of the field of gender and age in religious and spiritually oriented coping. It presents and analyzes findings re-

vealing the gender- and age-directed character of choices in religious and spiritually oriented coping methods.

    Chapter 9 contains a detailed discussion of my findings on the basis of the findings and analyses presented in previous chapters. In this chapter, the questions initially put forward in this study will be answered.

Note:

[1]The Many Methods of Religious Coping called RCOPE is a theoretically based measure developed by Pargament and his colleagues (Pargament et al. 2000). The measure assesses different religious coping methods. I have compared the results of my study with RCOPE. In Chapter 4, there is a detailed explanation of RCOPE and of how it has been used here.

Chapter 2: Coping, Religion and Spirituality

In this chapter, I will discuss religious and spiritually oriented coping in a general perspective, with an emphasis on factors of importance to this study.

An Introduction to the Concept of Coping

What Is Coping?

The concept of coping has been essential in Psychology for more than 60 years. Generally, coping is regarded as the means we use to combat or prevent stress. It can be defined as a process of managing the discrepancy between the demands of the situation and the available resources – a process that can alter the stressful problem or regulate the emotional response. As Lazarus and Folkman (1984:141), the prominent scholars in the field, emphasize, coping is:

> constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.

These cognitive and behavioral efforts are, as they write in a later work, "constantly changing as a function of continuous appraisals and reappraisals of the person-environment relationship, which is also always changing" (Folkman & Lazarus 1991:210).

Lazarus and Launier (1978) define coping as efforts, both action-oriented and intrapsychic, to manage (that is, master, tolerate, reduce, minimize) environmental and internal demands and the conflicts between them, which tax or exceed a person's resources.

Coping may also be defined as the process through which individuals try to understand and deal with significant demands in their lives (Ganzewoort 1998:260) or as a search for significance in times of stress (Pargament 1997:90). By significance, Pargament refers to, "what is important to the individual, institution, or culture – those things we care about" (1997:31). Significance, according to Pargament (ibid.), includes "life's ultimate concerns – death, tragedy, inequity". It encompasses also other possibilities, "possibilities that are far from universal, possibilities that may be good or

bad" (ibid.). The concept of significance is important in Pargament's theory of coping, especially religious coping.

According to Hobfoll (1988:16), coping constitutes those behaviors employed for the purpose of reducing strain in the face of stressors.

Coping is regarded (Lazarus & Folkman 1984:148; Pargament 1997:89) as a multilayered contextual phenomenon with several basic qualities. In this regard, Pargament (1997:89) stresses that coping "involves an encounter between an individual and a situation; it is multidimensional; it is multilayered and contextual; it involves possibilities and choices; and it is diverse." Another dimension of coping is that it is a process, one that evolves and changes over time.

Several components are important in coping: coping strategies, coping style, coping resources and burdens of coping.

Coping Strategies

Coping strategies refer generally to those efforts, both behavioral and psychological, that people facing a difficult situation employ to master, reduce or minimize stressful events. Coping strategies mediate evaluation of the significance of a stressor or threatening event as well as evaluation of the controllability of the stressor and a person's coping resources.

Two general coping strategies are recognized: problem-solving strategies and emotion-focused coping strategies.

Problem-solving strategies are efforts that actively ease stressful circumstances. In emotion-focused coping strategies, efforts are directed toward regulating the emotional consequences of stressful events. Research (Folkman & Lazarus 1980) has shown that people use both types of strategies when fighting stressful events. Different factors play a role in choice of one type of strategy over the other; personal characteristics and type of stressful event are among the important factors. It seems that, when dealing with potentially controllable problems such as family-related problems, people employ the problem-solving style, whereas when facing less controllable situations, such as serious physical health problems, people tend to employ emotion-focused coping.

Two general goals of coping strategies are recognized: to alter the relationship between the self and the environment and to reduce emotional pain and distress. Different individuals have different ways of approaching these goals. Researchers (Lazarus & Launier 1978; Billings & Moos 1981) divide coping strategies into the categories active and avoidant (or passive) on the basis of the way a person faces the stress, illness or loss. Active coping means doing something to affect the stressor, while avoidant coping means being escapist and passive.

Active coping strategies are behavioral and psychological responses that can change the nature of the stressor itself or impact a person's attitude to-

ward the event. Active coping strategies allow the patient to take responsibility for management of the physical as well as psychological effects of illness. Active coping may include different ways of involving the patient in physical therapy or another exercise plan, relaxation for reducing mental strain, and distracting the patient's attention from the stress and pain.

Using avoidant coping strategies, the patient leaves responsibility for management of stress and/or pain to an outside source or allows other areas of life to be adversely affected by her/his stress and/or pain. Some researchers, such as Holahan and Moos (1987), consider that active coping strategies constitute better ways of dealing with stressful events, while avoidant coping strategies constitute adverse responses to stressful life events.

Other researchers, such as Pargament (1997:87), believe that we can hardly speak of passive coping strategies, because:

> Even if a passive, avoidant, or reactive stance is taken toward problems, this does not erase that, at some level, the stance was chosen. In this very basic sense, coping is an active process involving difficult choices in times of trouble.

Like Pargament, I have difficulty categorizing the endeavor of a person who chooses to react passively to her/his problem as a passive coping strategy, especially if we consider that avoidant coping strategies often bring to the fore activities (such as alcohol use) or mental states (such as withdrawal) that keep the patient from directly thinking about the stressful event she/he is facing. Thus, the patient is not actually passive when facing the problem her/his illness causes.

Coping Styles

Coping styles may be defined as generalized ways of behaving that can affect a person's emotional or functional reaction to a stressor and that are relatively stable across time and situations. Different styles have been identified that represent those patterns of thought, feeling and behavior that a person may display when facing a serious illness. Greer and Watson (1987) have distinguished five adjustment styles among cancer patients:

Fighting Spirit: 'This is a challenge. I will win.'
In this style, the patient regards the illness as a challenge. This usually leads to a positive attitude with regard to the outcome. The patient often tries to actively influence the process of treatment by seeking information from various sources such as local information centers, the Internet and by making full use of the medical and alternative options available to her/him.

Avoidance or Denial: 'It is not that serious.'

Here the patient denies the threat inherent in the diagnosis. Sometimes this style may be useful, but only if it does not interfere with accepting treatment. This style is regarded as a form of distraction, which allows the patient to get on with life with a positive attitude.

Fatalism: 'It's out of my hands' or 'what will be will be'.

In this style, the attitude of the patient is passive acceptance. The patient rarely tries to gather information or challenge the situation. She/he trusts the doctors and accepts any treatments offered. Although this passive style may be frustrating for friends and relatives, it does keep darker and more difficult emotions at bay.

Helplessness and hopelessness: 'There is nothing I can do. What is the point of going on?'

Here, the patient 'gives up'. Any effort to tackle the problem is seen as useless. Feelings of helplessness and hopelessness are often predominant.

Anxious preoccupation: 'I am so worried about everything all the time.'

In this style, the patient spends considerable time worrying about the cancer. She/he assumes that any physical symptom is part of the disease. Excessive information-seeking feeds the fear, which at times can be unbearable and lead to panic. When the patient is waiting for test results and appointments, she/he often becomes impatient and panicky.

Each of the five styles listed above gives the person a way of dealing with the uncomfortable thoughts and feelings caused by her/his illness. Some patients use all or some of these five categories at different times during the initial adjustment period. There are certainly many factors influencing the patient's choice of coping style. Among these factors are the particular coping resources and burdens of coping the patient brings to the coping situation.

Coping Resources and Burdens of Coping

Coping Resources: As Pargament (1997:101) stresses, the resources individuals bring to coping may be material (e.g., money), physical (e.g., vitality), psychological (e.g., competence), social (e.g., interpersonal skills) or spiritual (e.g., feeling close to God). Through research, some coping resources have been identified and examined. Problem-solving skills constitute one such resource. It is supposed (Dubow & Tisak 1989) that people with good problem-solving skills have fewer behavior problems than do those with less developed problem-solving abilities. According to some researchers (Noris & Murell 1988), prior experience with a stressor is an effective coping resource. Social support constitutes another resource in times of

stress (Cohen & Wills 1985). Another resource is having a tendency toward pursuing goals tenaciously and adjusting goals (Pargament 1997:101). An additional effective coping resource is believed to be religion, but it can also play the role of a burden (we will return to this issue when we discuss the positive and negative patterns of religious coping).

Burdens of Coping: Like coping resources, burdens of coping may be material, physical, psychological, social or spiritual. Examples of such burdens are a history of failure, a physical handicap, a destructive family, a personality problem, financial debt or dysfunctional beliefs about oneself or others (Pargament 1997:101). Several studies have been carried out to determine the effects of burdens of coping. For example, a longitude study of the relationship between pessimism and physical health (Peterson et al. 1988) shows that a pessimistic explanatory style was predictive of poorer physical health among certain sub-groups of the study population. A study carried by Wheaton (1983) indicates that fatalistic beliefs and inflexibility in coping may function as a burden.

Both the resources and burdens people bring with them to coping contribute to an orienting system (Kohn 1972) that may be defined as a

> general way of viewing and dealing with the world. It consists of habits, values, relationships, generalized beliefs, and personality. The orienting system is a frame of reference, a blueprint of oneself and the world that is used to anticipate and come to terms with life's events. The orienting system directs us to some life events and away from others" (Pargament 1997:99-100).

An orienting system that guides and grounds individuals faced with a crisis is, indeed, a frame of reference (a material, biological, psychological, social and spiritual one) for thinking about and dealing with life situations. Some orienting systems may be stronger and more comprehensive than others. Yet any system has its points of weakness and limitations (Pargament 1997:102). An orienting system is not static, but changes over time. In other words, coping resources are not only used, but also developed, and burdens are not only taken on, but also lightened (Pargament 1997:104).

   An orienting system actually represents the way in which culture imposes its impact on the individual's life and therefore the way she/he copes with stress when facing intrusive circumstances. One of the qualities of coping is, as mentioned, that it is a multilayered contextual phenomenon. Pargament points out (1997:85) that it is not possible to remove the individual from the layers of social relationships – family, organizational, institutional, community, societal and cultural. One of the most important layers of social relationships is culture. However, in coping studies, the fabric of cultures – rules, roles, standards and morals – once a part of the background of life are

rarely noticed (Pargament 1997:73). As Aldwin (2000:191) stresses, in the research field of coping it is accepted that the situational context affects coping (Eckenrode 1991; Moos 1984), but acceptance of the effects of sociocultural context on the coping process is not widespread. Because, as mentioned, the main objective of this study is to investigate the role of culture in the use of religious and spiritually oriented coping methods, I will now discuss more thoroughly the role of culture in coping.

Coping and Culture

The Role of Culture in Coping

Before discussing the role of culture in coping, it is perhaps necessary to define what I mean by culture. I refer to culture as a system of norms and values that is shared by the members of a society, a community or a group and the explicit expression of these norms and values. These norms and values are necessary for construction of individuals' identities and of their ethical and moral world, which in its turn functions as an orienting system in social relationships. Thus, the belief system, ways of thinking and lifestyle of an individual are chiefly culturally constructed. Culture influences, accordingly, the "complex whole" of social life: its institutions, laws, knowledge, customs, morals and lifestyles (Taylor 1968).

Coping is, among other things, a behavior chosen to face a certain stressful situation. This behavior, like many other behaviors of an individual, is a manifestation of certain attitudes. These attitudes, in turn, express the norms and values that the individual has internalized during her/his socialization in a certain society. Individuals' views of and attitudes toward politics, the economy, professional life, sexual and family life, religion and morality play an important role in how they deal with a stressful situation. Culture, as the framework of such views and attitudes, has hence a determining effect on the choice of coping methods in a stressful situation. In short, culture shapes coping.

Being embedded in culture, coping takes on different colors. As Pargament (1997:117) stresses "Coping plays out against the background of larger cultural forces. In the language of coping, culture shapes events, appraisals, orienting systems, coping activities, outcomes, and objects of significance". In other words, culture provides the grounding in the search for significance (Pargament 1997:119). Caudill (1958) describes how, in a stressful situation, the individual and culture are related to each other. For instance, some research (MacReady & Greely 1976) shows that Americans used to carry a legacy from the cultures of their ancestors in their responses – religious or non-religious – to the most basic problems associated with living in the

United States. Aldwin (2000:193) describes four ways in which culture can affect the stress and coping process:

> First, the cultural context shapes the types of stressors that an individual is likely to experience. Second, culture may also affect the appraisal of the stressfulness of a given event. Third, cultures affect the choice of strategies that an individual utilizes in any given situation. Finally, the culture provides different institutional mechanisms by which an individual can cope with stress.

Emphasizing the role of culture as an essential factor in determining the behaviors, attitudes and views of individuals does not imply that culture is the only variable influencing coping. It is likely that gender, age, socioeconomic status, education, development over the life span and mental health all play a significant role in coping.

That culture and social forces influence the ways in which people cope with crises does not mean that coping lacks an "individual character". By "individual character" of coping I mean the role personal characteristics play during the coping process. What is emphasized especially is the role of individuals as decision-makers. Yet the "individual character" of coping does not diminish the role of culture in coping. Culture, as an essential component in shaping the identity of the individual, is also present in the decision-making process. The "individual character" of coping actually shows the non-deterministic character of choices in coping. As Pargament (1997:87) stresses:

> Coping rejects the notion of psychic determinism as well as social determinism. The assumption that the response to crisis is not fully determined, but rather at least partially chosen, sets coping apart from defense mechanisms. This is not to say that people are aware of their choices. Not all coping is fully conscious. Some ways of dealing with stressors may be so well learned that they require very little conscious processing. …Nevertheless, the concept of coping embodies a greater appreciation of the capacity for proactive decision making and conscious awareness in stressful situations than the concept of defense, which is said to be instinctually driven and largely unconscious.

The "individual character" of coping makes it meaningful to study which types of individual characteristics are helpful or harmful in coping.

Studies (Smitt 1966; Tyler 1978; Pargament et al. 1979) have been conducted to determine which types of people are successful in coping with difficult life events. In this connection, Tyler (1978) has developed a tridimensional model of the competent self. Pargament (1997:81) explains this model as follows:

> Effective people, he said, have a favorable set of attitudes toward themselves. They see themselves as worthwhile and efficacious in their lives whether

things go well or poorly. Effective people also have a favorable set of attitudes toward the world, a sense of moderately optimistic trust in others. Finally, effective people are characterized by an active problem-solving orientation.

The above-mentioned study shows that certain personal characteristics, more than others, are important for the choice of effective coping methods. It is, however, undeniable that culture is not only an essential factor in the construction of such characteristics, but it also "makes some ways of thinking about and dealing with critical problems more accessible and more compelling to its members than others" (Pargament 1997:190). For instance, as regards religion, the culture selectively encourages some religious expressions in coping and selectively discourages others (ibid.).

Being sociological in nature, the research on which this book is based has focused only on the cultural aspects of coping. Proceeding from a cultural perspective, I have tried to discover the impact of culture in encouraging or discouraging the use of religion and/or spirituality in coping.

Culture, Religion and Coping

Culture is an essential component in the construction of the belief system. We can hardly deny that the world religions[1] such as Christianity, Islam and Buddhism have taken on different characteristics depending on the cultural setting in which they developed. As Tarakeshwar et al. (2003:377) stress "Religion is inextricably woven into the cloth of cultural life. The myths, symbols, and rituals tied to religion can be understood as ways of making sense of the world". Not only does culture shape religious beliefs and practices, but religion, in its turn, occupies an essential position in some people's lives across different cultures. One example showing the extent to which differences in the manifestation of religious faith can contribute to differences in the cultural dimension is the conflicting cultural trends in Egypt and Iran. As Tarakeshwar et al. (2003:378) point out "In Egypt, on one hand, growing literacy appears to be strengthening the religious faith of the populace; in Iran, on the other hand, the strongest support for democratic reforms and opposition to clerical power has emerged from a major seat of learning, the Iranian universities".

The current view of religion's role in coping is that religion is a defense mechanism against confrontation with reality, a tension reducer, a form of denial and a passive way of confronting crises (Freud 1961; Cox 1980). Pargament and Park (1995) consider that this view, i.e. "religion-as-defense", is stereotypical and neglects the notion that religion is a complex multidimensional phenomenon, especially with regard to coping. In coping, religion responds not only to the search for comfort, but also to other ends related to, e.g., the sacred, meaning, the self, physical health, intimacy and a

better world (Pargament 1997:167-168). Yet we should not forget that religion also has a darker side that may be revealed in coping. We will return to this point.

One of the important issues when discussing religious coping is to discover the circumstances under which religion and coping converge. One of the answers is that religion is more available to the individual when it is a larger part of her/his orienting system (Pargament 1997:144). As mentioned, an orienting system is a way by which culture makes its impact on the individual's life. Such being the case, it is convenient to maintain that one reason people turn to religion in a time of crisis is that religion is more accessible in their sociocultural context than are other resources. In other words, people have more access to religion as a tool for coping with difficult situations when their religious beliefs, feelings and practices are a part of their culture, and therefore a part of their orienting system. But as Pargament mentions (1997:145), religion is not the only resource available in the individual's orienting system, other resources may be easier to access. Such being the case, religion may take on even greater power as a coping resource for those with limited alternatives. In cultures with greater non-religious resources and where religion is less involved in the everyday life of individuals, religion may be less involved in coping. The question of "turning to religion in coping" is, therefore, primarily one of the position of religion in the culture in which the person who is coping has been socialized. As Pargament (1997:147) explains:

> To the extent that religion becomes a larger and more integrated part of the orienting system, it takes on a greater role in coping. To the extent that religion becomes less prominent in the orienting system, more disconnected from other resources, and less relevant to the range of life experiences, it recedes in importance in coping.

Some studies (Wicks 1990; Kesselring et al. 1986) have shown that, in certain cases, people do not use religion in coping regardless of whether it is an important component of their life. As these studies show, in some cases, individuals for whom religion has never been important did not change their attitude toward religion when faced with a stressful situation. In other cases, individuals for whom religion has always been important did not use religion in a time of crisis. These studies show that, in addition to the position of religion, there are other forces that influence the involvement of religion in coping, i.e., social forces such as class affiliation, education, etc.

One study shows (Neighbors et al. 1983) that, among adult black Americans, those with lower incomes found prayer to be the most helpful coping response (the proportion was 50.3% for lower income and 34.9% for higher income). The same study shows that prayer was described as more helpful by females (50.7%) than by males (30.2%), and by the older group (64.3%)

than by the middle-age (46.6%) or younger (32.2%) groups. Other studies (Bijur et al. 1993; Ellison 1991; Ferraro & Koch 1994) also indicate that, in the United States, religious involvement in coping is more evident among members of less powerful groups in society, such as blacks, women, old people and people with low incomes. The study shows that religious coping has been more helpful for these groups than for other groups (Ellison 1991; Pollner 1989).

According to Pargament (1997:301), one factor explaining why religion should be more helpful to these groups in coping is that, in the American culture, they have less access to secular resources and power. Religion for them represents a resource that is more easily accessed than are the secular ones. This shows again the undeniable role of culture and social forces in determining the role of religion in coping.

Although some researchers (e.g., Pargament 1997) have pointed out the role of culture in coping, the importance of culture is not seriously taken into consideration in the research field of religion and coping. In fact, when discussing the significance of religion in coping, the point of departure has often been research conducted in the United States. For instance, Pargament, in his book "The Psychology of Religion and Coping," discusses the role of religion in coping from different perspectives. One aspect he stresses frequently (e.g., Pargament 1997:137) is that, according to many studies, religion looms large with regard to different forms of coping. Almost all the studies he references were conducted in the United States. In general, discussions in Pargament's book are very rarely based on studies conducted outside the United States.

The lack of cultural approaches to the study of religious coping makes it necessary to investigate whether religion truly occupies an elevated position in coping in every society or whether it is only in certain sociocultural contexts that people frequently and/or habitually turn to religion in coping.

The position of religion as well as the accessibility to non-religious resources in Sweden and some other European countries is different from the situation in the United States. For instance, Swedes seem to be more spiritually oriented than religiously oriented. Such being the case, it is interesting to see which differences this cultural characteristic makes in the way people use the religious or spiritually oriented coping methods. In other words, if we accept that the cultural and social characteristics of a society fundamentally determine the role of religion in coping, we should wonder whether people turn to religion or spirituality when facing a critical problem even in societies where religion does not play an essential role in the everyday life of individuals. And what role do religion and spirituality play in coping in societies where secular resources are more available for the majority of citizens than are religious ones? My study among Swedes constitutes an attempt to answer these questions.

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Religious and Spiritual Coping

Religious and Spiritual Coping and Sanctification

Sanctification is an important phenomenon, which should be of keen interest to those studying religious and spiritually oriented coping. Astonishingly, this phenomenon has not received a great deal of attention. One reason may be that sanctification does not directly bear upon institutional religious involvement. Moreover, the sacred cannot easily be discerned in people's coping experience.

Because a discussion on sanctification will be used for analyzing some of the results obtained in this study, I will try to shed light on the importance of sanctification for religious coping. In this regard, I have proceeded mainly from Pargament and Mahoney's (2005) interesting discussion on sanctification.

Regarding the sacred qualities as manifestations of both God and the divine as well as the transcendent, sanctification is defined "as a process through which aspects of life are perceived as having divine character and significance…..a process of potential relevance not only for theists but nontheists as well" (Pargament & Mahoney 2005:183). Here, sanctification is seen as a "psychospiritual" construct. This is explained as follows:

> It is spiritual because of its point of reference – sacred matters. It is psychological in two ways; first, it focuses on a perception of what is sacred. Second, the methods for studying sacred matters are social scientific rather than theological in nature.

The process of sanctification not only occurs in relation to theistically oriented interpretations of various aspects of life, but also indirectly, which means that perceptions of divine character and significance can develop by investing objects with qualities associated with the divine (Pargament & Mahoney 2005:185). These sacred qualities include, according to Pargament and Mahoney (ibid.), attributes of transcendence (e.g., holy, heavenly), ultimate value and purpose (e.g., blessed, inspiring) and timelessness (e.g., everlasting, miraculous). Although people could conceivably attribute sacred qualities to significant objects in a God or higher power, meaning therefore that any aspect of life may be perceived as sacred, the choice of the sacred is not arbitrary (ibid.). Several factors affect this choice. Pargament and Mahoney (2005:187) stress the role of religious institutions as one key source of education about sanctification. Besides these institutions, "organizations, communities, and the larger culture as a whole define what is and what is not sacred, what is to be revered and what is not" (ibid.). As we will see in Chapter 7, my study shows the impact of culture on the choice of sacred object[2] when coping with the stressors associated with cancer.

The sanctification process can affect coping. This is because sanctification may influence the key dimensions of human functioning, among which are: (1) the ways people invest their resources; (2) the aspects of life people preserve and protect; (3) the emotions people experience; (4) the individual's sources of strength, satisfaction, and meaning; and (5) people's areas of greatest personal vulnerability (Pargament & Mahoney 2005:192)

When facing a difficult situation, people invest different available resources in order to cope. Sanctification may play an important role (negative or positive) in this respect. Through sanctification of different objects such as one's job, children, marriage, etc., people reorient their focus of attention in times of crisis. A change of focus from the problem to the sacred object may offer the individual a sense of security.

It is not unusual for people facing crises to make extraordinary efforts to preserve certain objects, phenomena or certain aspects of their life. In this respect, one method of preservation is the sanctification of these objects or aspects of life. Becker (1998:34) gives us an example of a women sentenced to life imprisonment who invested an old chair with sacred character. Sanctification of the chair played an important role in bringing comfort and security to this woman; it was a way to cope with her difficult situation in prison. The woman in questioned explained that

> With persistence and hard work I managed to get the chair sanded down, stained, and nailed back together, the chair was the beginning of the long, slow process of putting my life back together… It is difficult for me to describe the comfort and security my chair has brought me. Because of all the times I have prayed or meditated in it, it has become a sacred object. Throughout the years and all the changes they have brought, it is the one thing that has remained the same (Becker, 1998:34).

In my study, I have found that the sanctification of nature is used in coping. This will be discussed in Chapter 7 and 8.

Assumptions on Religious Coping

Religious coping illustrates the way individuals use their faith in dealing with stress. Different approaches to the problem-solving process have been found to relate differently to religious motivations, conceptualizations of God and psychological adjustment (Wong-Mcdonald & Gorsuch 2000:149).

There are certain assumptions concerning the ways in which religious cognitions and practices are fashioned into patterns of stress management, physical and mental well-being, personal mastery and internal locus of control, especially in the case of individuals facing certain life events and difficult conditions. Event Specificity and Religious Role Taking are the most dominant assumptions in the field.

Concerning the Event Specificity assumption, it is suggested that certain life events are particularly likely to elicit religious coping responses; these events include illness and physical disabilities (Jekins & Pargament 1988; Pargament & Hahn 1986). There are a number of hypotheses concerning why religious coping should be particularly effective in response to the specific conditions. One of them, as Ellison (1994:104) describes, suggests that "individuals continually struggle to maintain the perception of a "just" world, a world in which good fortune comes to good people and bad people get what they deserve". Events and situations such as serious illness, unyielding pain and sudden death often violate such assumptions. According to Ellison (1994:104), by "reframing these events in broadly religious terms, individuals may be able to manage their emotional consequences while still salvaging their belief in a just world".

According to the Religious Role Taking assumption, individuals may experience a divine personification through identification with various figures portrayed in religious texts (Pollner 1989). In this connection, Ellison (1994:105) points out that "Individuals may resolve problematic situations more easily by defining them in terms of a biblical plight and by considering their own personal circumstances from the vantage point of the 'God role'". This being the case, facing serious illness may cause people to draw on scriptures and devotional practices in confronting specific stressors. In my study, I have investigated whether informants have used the abovementioned ways of dealing with their stressors.

Religious Coping Styles

Distinctive approaches to responsibility and control in coping have been identified. As Pargament (1997:293) explains, control may be centered differently. Four approaches are identified (ibid.):

Control may be centered in God. Believing that life rests in the divine, the individual may passively defer to God in troubled times.

Control may also be centered in efforts to work through God. The individual may attempt to influence God and the course of events through pleas for divine intercession.

Control may be centered in the relationship between the individual and God. The individual may feel a sense of partnership with God, one in which the responsibility for coping is neither the individual's alone nor God's alone, but rather shared.

Control may be centered in the self, growing out of the belief that God gives people the tools and resources to solve problems for themselves.

On the basis of these different approaches, Pargament et al. (1988) have developed the concept of "religious coping style". By coping style they mean "relatively consistent patterns of coping in response to a variety of situations" (Pargament et al. 1988:91). Studies (Pargament et al. 1988;

McIntosh & Spilka 1990; Sears & Green 1994) have shown three broad styles of religious coping:

- *Deferring*: A 'deferring' religious problem-solving style in which the individual passively waits for solutions from God. Deferential religious copers seek control over problematic situations through a divine other, who then becomes a psychological crutch. Because this style is associated with lower levels of competence, it is regarded as part of an externally oriented religion. Research conducted by Pargament et al. (1998) indicates that a deferring coping style is connected with a religious orientation in which fulfilling individual needs involves looking for external rules, convictions and authority.

- *Collaborative*: A 'collaborative' religious problem-solving style involves active personal exchange with God (Kaldestad, E. 1996:9). Collaborative religious copers, as Ellison explains, "perceive themselves as being actively engaged in dynamic partnership with a divine other" (Ellison 1994:105). A collaborative religious coping style appears to be part of an internalized committed form of religion, one that has positive implications for the competence of the individual. In their study, Pargament et al. (1988) show that this coping style is related to an individual religious orientation in which religion is the motivating life force.

- *Self-directing*: In a 'self-directed' religious style, the individual does not lean on God. "Self-directed religious copers employ religious cognitions and activities only sparingly in response to stressors" (Ellison 1994:105). It is the individual's responsibility to solve problems through the freedom God gives people to do so. Compared with the other two styles, the connection to traditional religiousness is very weak.

Wong-McDonald and Grouch (2000) proposed an additional coping style, which is called "Surrender to God". A 'surrender' style of coping is not, as the writers point out, a passive waiting for God to take care of everything; rather, it entails an active choice to relinquish one's will to God's rule (Wong-McDonald & Grouch 2000:149). According to Wong-McDonald and Grouch (2000:149), a study of 151 Christian undergraduate students shows that we can delineate "Surrender as a separate factor from the other coping styles".

In explaining this additional style, Wong-McDonald and Grouch (2000:150) write:

> We propose that surrender may present a coping style of more committed believers, characterized by an internal motivation to follow God and act in obedience despite the costs (e.g. I will follow God's solution to a problem regardless of what that action may bring). This is different from the deferring style of not assuming responsibility, but wanting solutions (i.e. for God to "fix" the situation without taking action).

Regarding the relation between the above-mentioned styles and the degree of religious commitment, some researchers (Schaefer & Grouch 1993; Smith & Grouch 1989) maintain that degree of commitment to religious beliefs may affect variations in religious response to varied situations. In this regard, Wong-McDonald and Grouch (2000:150) stress that:

> Less committed Christians trend to be more self-directive or referring, whereas more committed ones may choose to work collaboratively with God (Pargament et al. 1998).

This opinion is not shared among all researchers in the field. Some do not see such a direct relation between degree of commitment and religious response to difficult situations. For instance, Jenkins and Pargament (1995:54) point out that, despite the importance of denominational concerns, religious beliefs and practices may be divorced from formal ties to any religious organization. Jenkins (Jenkins & Pargament 1995:54) points out that when he interviewed cancer patients about their coping, some patients made comments such as the following: "You know, I haven't been to church in 25 years, but having cancer has made me think about whether this disease may have some kind of meaning in terms of my place on Earth". In the same vein, Pargament (1997:181) stresses that although the self-directing style was found to be negatively associated with most of the measures of religiousness, it does not constitute a non-religious approach. In his study, people who were more self-directing also tended to maintain an affiliation with their church.

Here I should mention that even though the self-directing style is, according to Pargament (1997:293), based on the belief that God gives people the tools and resources to solve problems for themselves, it is, in my opinion, problematic to consider the self-directing style a religious coping style. If an individual has centered the control to her-/himself and states that "When I have difficulty, I decide what it means by myself without help from God" or "I act to solve my problems without God's help,"[3] this means that religion does not play a role for this individual when she/he deals with difficulties. Here it does not matter whether or not this person believes in God or has an affiliation with her/his church. What is important from the point of view of the psychology of coping is that the person in question chooses to cope in stress situations independent of God's input and relies only on her-/himself. I believe that such an approach can hardly be categorized as a religious one. I will return to this issue when presenting the results of my study among Swedes.

Taking an outcomes approach, some researchers (Pargament et al. 1988; Wong-McDonald & Gorsuch 2000) have found that collaborative religious coping is related to positive outcomes, such as increased self-esteem, spiritual well-being and lower levels of depression. As some studies show, a de-

ferring style (Pargament et al. 1988; Wong-McDonald & Gorsuch 2000) "appears to have mixed implications, relating to higher levels of depression, lower levels of competence, but also tied to higher levels of spiritual well being" (Phillips III et al. 2004:409). A self-directing coping style is also found (Hathaway & Pargament 1990; Pargament et al. 1988; Wong-McDonald & Gorsuch 2000) to be associated with mixed outcomes. This style has been related to higher levels of self-esteem and belief in personal control, but also to higher levels of depression and lower levels of spiritual well-being (Phillips III et al. 2004:409). In one study (Phillips III et al. 2004), self-directing religious coping was correlated with positive and negative outcome variables identified in previous research. One of the questions posed in this study was whether a self-directing style is related to a deistic God concept, an abandoning God concept or no God at all. As this study shows, the Self- Directing Scale (SDS)

> does not appear to be a measure of a perception of a Deistic God. The self-directing scale does moderately correlate with an abandoning God concept, suggesting that at least a component of the variance within the SDS reflects this subcontract. The self-directing scale also appears to reflect less though more research is needed here (Phillips III et al. 2004:416).

Regarding the correlation between self-directed coping and depression, one study (Bickel et al. 1998) shows that personal control over a situation moderates the relationship between a self-directing versus a collaborative God in relation to depression. As Phillips III et al. (2004:416) explain:

> for those high in self-efficacy, the lack of belief in an intervening god may not be particularly problematic. ..in situation with low personal control, frequent endorsement of self-directing religious coping was related to higher levels of depression while collaborative coping was associated with lower levels of depression.

In my opinion, one of the problems underlying the mixed outcomes for self-directed coping is that the endeavors of people who are trying not to rely on God are regarded as religious coping. Some researchers, among them Pargament himself, pinpoint this problem when explaining (Phillips III et al. 2004:410) why some studies presented mixed results for self-directed coping.

> One potential explanation for this inconsistency may lie in the operationalization of the construct itself. Perhaps the SDS does not measure what it was intended to measure.

Such being the case, informants could conceivably interpret the self-directing items in several ways. Phillips III et al. (2004:410) discuss some possible interpretations of the scale: Although the original assumption is that

God has indeed provided individuals the ability and freedom to engage in the problem-solving process, people could proceed from the interpretation that God does not intervene but is supportive of the individual throughout the coping process. The person may also believe that she/he must cope alone because God has abandoned him/her or, finally, self-directed items may be endorsed because the participant is not very religious and thus does not involve God in the coping process. It is notable here that the writers discuss the possibility of a participant being "not very religious", but not that the participant may be non-theist or atheist. This may be because the research on which the different coping styles are based was conducted in the United States, where according to the American Religious Identification Survey of 2001, 81% of the adult population identified with one or another religion group (Kosmin et al. 2001). Conducting similar research on different coping styles in a cultural context other than the American one will probably provide us with different results. In cultural settings like the Swedish one, it may be expected that the last interpretation of the self-directing scale will be more prevalent among people than are the other interpretations. The lack of cultural studies constitutes a serious problem for research on religious coping styles. Some studies – such as Alma's survey (1998) conducted among 237 members of local congregations of Protestant churches in the Netherlands and Pieper and van Uden's (2001) study conducted among 118 patients in an orthodox Reformed Psychiatric hospital also in the Netherlands – support this point. In both studies, modified versions of the "Three Styles of Religious Coping Scales" (Pargament 1997:180-183) were applied. Application of these scales entailed some problems, mainly because the scales are not sufficiently sensitive to different cultural settings. Alma et al. (2003:71) stress,

> When developing the scales for the Alma study, there was a growing dissatisfaction with the statements that were meant to measure the religious coping styles: careful translation into Dutch revealed their American character even more strongly…

One risk of applying the scales of religious coping without taking into consideration the cultural aspect of coping is, as Alma et al. (2003:71) point out, that "the statements will be completely alien to the respondents". Alma et al. do not mention the need for a cultural approach in studying the different religious coping styles, what they emphasize is the need for sensitivity to other religious lives. They (Alma et al. 2003:72) state that:

> The results from the interviews reinforced our conviction that Pargament's grouping fails to do justice to the complexity of religious life. Naturally, we realize that over the past years Pargament has tried to optimize his instruments for assessment… We nonetheless believe that even the various scales of recent developed ignore a crucial dimension. In particular we think that the

> Pargament scales focus too much on a view of an active, personal God and that, therefore, a diffuse relationship with a more impersonal God, certainly not uncommon in the secularised Netherlands, is not take into account.

Although Alma et al. (2003:70) criticize that the "Three Styles of Religious Coping Scales" are not able to capture the complexity of religious life, they do not see a problem with categorizing a self-directing style as a religious coping style, especially with regard to the non-theists and atheists. This may be because both the Alma survey (1998) and Alma et al. (2003) focused only on theist people who had been socialized in cultural environments other than the American one. In research on a more varied population that embraces not only theists, but also non-theists and atheists, the difficulty in understanding and interpreting the ways in which styles of religious coping are operationalized will be much greater. For solving this problem, we need to conduct more sophisticated and more culturally sensitive studies.

Positive and Negative Patterns of Religious Coping

As Pargament et al. (2000:524) maintain, although "the concept of coping has a positive connotation, coping can be ineffective as well as effective".

Spiritual support may act through "cognitive mediation", by contributing to a positive cognitive appraisal of the meaning and implication of negative life events (Coleman 1992), or by enhancing perceptions of being valued, loved and cared for by God, and consequently by increasing self-esteem and reducing negative affect (Dein 1997:295).

Some studies, especially among the elderly, indicate that religious belief is related to physical health and well-being and that religion is a powerful cultural force in the lives of older medical patients. For instance using the Index of Religiousness, Pressman et al. (1990) looked at religion as a coping mechanism in elderly women with fractured hips and found religious beliefs to be associated with lower levels of depressive symptoms and better ambulatory status. Another study, well known as one of the most comprehensive studies on religious coping and depression, was conducted by Koenig (Koenig et al. 1992). He administrated a three-item index of religious coping to a sample of 850 men (over 65 years of age and with a range of physical diagnoses) and found that religious coping was a common behavior that was inversely related to depression in hospitalized elderly men.

One way in which religion may benefit people is through the attributions it provides. An important attribution is the selective incidence or "Why me?" question. Sickness may be seen as the result of God's will and therefore accepted or, as in the story of Job, seen as educational theodicy (Dein 1997). Perhaps religion functions by taking away responsibility from the sick person, lessening self-blame and consequently leading to a better psychological outcome (Gotay 1985; Linn et al. 1982). However, the reverse may also be

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the case: Patients may feel that God has let them down or become angry with them, leading to a worsened psychological prognosis (Litwood & Dein 1995). Actually, as some researchers (Atchley 1997; Levin 1994; Koenig 1995) have stressed, the relationship between measures of religiousness and psychological well-being is not consistent.

Although it has been suggested that religion can sometimes positively affect individuals' well-being (Ellison 1994; McFadden 1995), some empirical studies find a negative effect of religion on well-being. As Pargament et al. (2000:524) mention, "Religion also has its darker side". For instance, Baider and Sarell (1983) found that Israeli breast cancer patients who had fatalistic religious explanations for their disease coped less well than did those who had a more scientific world-view. Weisman and Worden (1976) found that church attendance was positively correlated with vulnerability to problems of adjustment. Other studies show the associations between religion and depression and grief among widows and widowers (Rosik 1989), between religion and poorer adjustment among terminally ill patients (Carey 1974), and between religion and depression among single middle-aged men and women (Rutledge & Spilka 1993).

In a study on the role played by religious beliefs and practices in the aging experience of the very old (aged 70-85) in Singapore, Muslims and the Indian Community comprising Hindus, Sikhs, Christians and one Jain individual were compared (Mehta 1997). Although this research demonstrates the positive influence of religion on the adjustment process in later life and on coping with different illnesses, it also shows that each ethnic group contained individuals who did not feel that religion had an important part to play in their lives. One of the negative impacts of religious beliefs observed in this study is the common practice of using explanations that indicate an external locus of control, such as Fate and Karma in the Malay and Indian communities, respectively (Mehta 1997:112). There were cases in which the use of such explanations discouraged the elderly from seeking appropriate forms of assistance. This was especially true in the area of health services and counseling (ibid.)

In another study, longitudinal data were used to examine whether the subjective importance attached to being a religious person at one point in time influenced health or psychological well-being 14 years later (Atchley 1997). The study indicated that religious affiliation and frequency of attending religious functions were unrelated to health or psychological well-being (Atchley 1997:131).

As we see, then, religion has its darker side and there are serious problems associated with integration of religion into the coping process. Investigating 40 studies on religious coping, Pargament (1997:315-356) studied, from different perspectives, what happens when religion fails in coping. According to him (Pargament 1997:285-286), some religious coping methods, such as spiritual support, collaborative forms of religious coping and

benevolent religious reframing, are associated with positive outcomes, while others, such as God's punishment and pleading for divine intercession, are related to negative outcomes.

The implications, and therefore the negative and positive outcomes of various methods of religious coping may change over time. Some methods that are helpful in the short-term may be problematic in the long-term. On the other hand, some methods may be associated with immediate discomfort, but prove to be functional in the long-term. It is also important to note that, as Pargament (1997:121) mentions,

> the end-results of coping are not necessarily all good or all bad. Oftentimes, coping leads to a "mixed bag," one that simply mirrors the difficult choices that must be made when confronted with the realities and limitations of decision making.

Such being the case, it is not obvious that certain ways of coping are always better than other methods. The nature of the problem as well as the person who faces it and the cultural setting in which the person is socialized may play a more important role than the method itself.

The crucial question is not, then, whether religion is lived or used, but how religion is used and to what ends. In line with the conception of religion as "means and ends" rather than "means or ends" (Pargament & Park 1995), coping theory describes religious ways of understanding and dealing with critical life events in the search for a variety of significant ends, spiritual and mundane. In my study, it was exactly this approach that was applied: The focus was on how religion was used. Moreover, I was open to the negative as well as positive patterns of religious coping. In this respect, I have not limited my study to effective and useful religious coping methods, but have also examined methods such as Punishing God Reappraisals, Demonic Reappraisals and Spiritual Discontent, which seem to be associated with distress.

The Many Methods of Religious Coping: RCOPE

Identifying any new and unknown religious and spiritually oriented coping methods used by informants has been the primary focus of my inquiry. My aim has been to find more culturally appropriate key functions of religion and spirituality that may explain the reason for use of religious and especially spiritually oriented coping methods by Swedes (or other groups among whom spirituality is more prevalent than religiosity). Although the present investigation is based on a qualitative study, it was necessary to take into consideration the established religious and spiritually oriented methods found in other studies – qualitative as well as quantitative. In this relation, I have compared the results of my study with what is called "The Many Meth-

ods of Religious Coping" or RCOPE. My reason for choosing RCOPE was that it is a relatively new measure based on theoretical as well as empirical studies. RCOPE includes many of the religious coping methods that have been found in different studies and has been tested on a large sample of different groups.

My aim was, among other things, to examine whether Swedish informants have used any of the religious coping methods belonging to RCOPE and whether culture has played a role in their using or not using RCOPE methods. As mentioned, Swedes have been socialized in a cultural setting very different from the one in which Americans have been socialized, and construction of RCOPE has been based on studies on Americans. My purpose, thus, has been to use a cultural approach to, among other things, comprehend the way in which RCOPE methods are used by the Swedish patients in this study.

Naturally, I have not confined myself to the RCOPE methods. Accordingly, RCOPE has not directed my study. I have taken into consideration RCOPE when structuring my interview guide and then used it after analyzing my interviews to examine whether there are any similarities between the coping methods found in my study and the coping methods listed in RCOPE.

What Is RCOPE?

RCOPE, as mentioned, is a relatively new "theoretically based measure that would assess the full range of religious coping methods, including potentially helpful and harmful religious expressions" (Pargament et al. 2000:521). This measure is based not only on the global indicators of religiousness (e.g., frequency of prayer, congregational attendance), but also on how the individual makes use of religion to understand and deal with stressors. Moreover, RCOPE reflects the non-static nature of coping. Coping is a process, according to Pargament (1997:89). As Ekedahl (2002:90) points out, Pargament's theory of religious coping is based on research on stress and coping that proceeds from the tradition of the psychology of self with emphasis on cognition. In this tradition, initiated by Lazarus and Folkman (1984), a process-orientation is in focus. This focus, however, takes the form of an end-oriented effort in Pargament's theory. In other words, Pargament is primarily interested in evaluating the coping process.

One of the advantages of RCOPE is that, as the spirit of comprehensiveness and scientific openness demands, it focuses not only on the positive dimension of religious coping, but also considers the potentially dysfunctional forms of religious coping. In this sense, methods that may be ineffective or harmful in dealing with stressful situations are also taken into consideration.

RCOPE is designed to assess five religious coping functions: meaning, control, comfort, intimacy and life transformation. Specific religious coping

methods were defined for each of these religious functions, and subscales were created.

Five key religious functions constitute the basis of RCOPE (Pargament et al. 2000:521). Because I use these key functions in my study, they are described in detail below.

> 1. Meaning. According to theorists such as Clifford Geertz (1966), religion plays a key role in the search for meaning. In the face of suffering and baffling life experiences, religion offers frameworks for understanding and interpretation.
>
> 2. Control. Other theorists, such as Erich Fromm (1950), have stressed the role of religion in the search for control. Confronted with events that push the individual beyond his/her own resources, religion offers many avenues to achieve a sense of mastery and control.
>
> 3. Comfort/Spirituality. According to the classic Freudian (1927/1961) view, religion is designed to reduce the individual's apprehension about living in a world in which disaster can strike at any moment. It is difficult, however, to separate comfort-oriented religious-coping strategies from methods that may have a genuine spiritual function. From the religious perspective, spirituality, or the desire to connect with a force that goes beyond the individual, is the most basic function of religion (Johnson, 1959).
>
> 4. Intimacy/Spirituality. Sociologists such as Durkheim (1915) generally have emphasized the role of religion in facilitating social cohesiveness. Religion is said to be a mechanism of fostering social solidarity and social identity. Intimacy with others, however, often is encouraged through spiritual methods, such as offers of spiritual help to others and spiritual support from clergy or members. Thus, again, it is difficult to separate out many of the methods that foster intimacy from methods that foster closeness with a higher power (Buber 1970).
>
> 5. Life Transformation. Theorists traditionally have viewed religion as conservational in nature - helping people maintain meaning, control, comfort, intimacy, and closeness with God. However, religion also may assist people in making major life transformations; that is, giving up old objects of value and finding new sources of significance (Pargament 1997).

Pargament et al. (2000:522-524) have defined religious and spiritually oriented methods, including potentially helpful and harmful methods, with respect to each of the five above-mentioned basic religious functions.

As mentioned, in order to recognize the different religious coping methods used by informants, I have compared the findings of my study with the definitions and items of religious coping in RCOPE. Hence, I have created a shorter list (see Table 1) of the definitions and items of different religious and spiritually oriented coping methods in RCOPE. The reason is that the definitions and items in RCOPE were mainly designed for use in quantitative

studies. Given the aim of my study, I have chosen to use a qualitative data gathering method. It was therefore necessary to "reconstruct" the RCOPE methods for use in a qualitative study. This "reconstruction" was in line with what the originators of RCOPE point out, namely that RCOPE

> does have a major drawback for researchers and counselors- namely, its length. However, researchers interested in studying the role of religion in coping with specific life stressors could choose RCOPE sub-scales that theoretically are tied to their subject of interest (Pargament et al. 2000:540).

Investigating whether the informants report having used any of the RCOPE methods gave me the opportunity to examine the five key religious functions described by Pargament et al. in the context of cultures, like the Swedish, in which people mainly do not practice their "religion" in a organizational way, but in a subjective and non-organizational way.

Besides the five mentioned key religious functions, another factors have been important in categorizing RCOPE methods, i.e., the positive and negative outcomes of the methods in questions. RCOPE methods are then grouped into two categories: positive methods and negative methods (Pargament et al. 1998). Positive religious coping methods are an expression of "a sense of spirituality, a secure relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others" (Pargament et al. 1998:712). Benevolent religious reappraisals, collaborative religious coping, and seeking spiritual support are examples of coping methods that fall within this category. Negative religious coping is an expression of "a less secure relationship with God, a tenuous and ominous view of the world, and a religious struggle in the search for significance" (ibid.). It includes punitive religious reappraisals, demonic religious reappraisals, reappraisals of God's powers and spiritual discontent. In the list of RCOPE, I used both the positive and negative coping methods.

In addition to religious copings methods similar to the coping methods listed in RCOPE, I have also found in my study religious and spiritually oriented coping methods that are not among the RCOPE methods. In Chapter 6, I will present those methods that have similarities with some of the RCOPE methods; I call them SRCOPE methods. In Chapter 7, those methods that I have called Spiritual Coping methods (SCOPE), which are totally independent of RCOPE, will be introduced and analyzed. The rest of this chapter is devoted to a short presentation of some studies on cancer and religious coping.

Table 1. List of the definitions and items of religious coping methods used in this study

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A - Religious Methods of Coping to Find Meaning

1. Benevolent Religious Reappraisal: redefining the stressor through religion as benevolent and potentially beneficial

- Tried to find a lesson from God/ a Spiritual Being in the event.
- Tried to see how the situation could be beneficial spiritually.

*2. Punishing God Reappraisal***:** redefining the stressor as a punishment from God/ a Spiritual Being for the individual's sins

- Wondered whether God/ a Spiritual Being was punishing me because of my lack of faith or my sins.

3. Demonic Reappraisal: redefining the stressor as an act of the "Devil"/ an evil power

- Decided the devil/evil power made this happen.

*4. Reappraisal of God's Powers***:** redefining God's/ a Spiritual Being's power to influence the stressful situation

- Realized that there were some things that even God/ a Spiritual Being could not change.

B. Religious Methods of Coping to Gain Control

1. Collaborative Religious Coping: seeking control through a partnership with God/ a Spiritual Being in problem solving

- Worked together with God/ a Spiritual Being to relieve my worries

2. Active Religious Surrender: an active giving up of control to God/ a Spiritual Being in coping

- Did my best and then turned the situation over to God/ a Spiritual Being.

3. Passive Religious Deferral: passive waiting for God/ a Spiritual Being to control the situation

- Knew I couldn't handle the situation, so I just expected God/ a Spiritual Being to take control.

4. Pleading for Direct Intercession: seeking control indirectly by pleading to God/ a Spiritual Being for a miracle or divine intercession
- Prayed for a miracle.
- Bargained with God/ a Spiritual Being to make things better.

5. Self-Directing Religious Coping: seeking control directly through individual initiative rather than help from God/ a Spiritual Being
- Depended on my own strength without support from God/ a Spiritual Being.

C. Religious Methods of Coping to Gain Comfort and Closeness to God

1. Seeking Spiritual Support: searching for comfort and reassurance through God's / A Spiritual Being's love and care
- Sought God's/ a Spiritual Being's love and care.

2. Religious Focus: engaging in religious activities to shift focus from the stressor
- Thought about spiritual matters to stop thinking about my problems.

3. *Religious Purification*: searching for spiritual cleansing through religious actions
- Confessed my sins.
- Asked forgiveness for my sins.

4. Spiritual Connection: experiencing a sense of connectedness with forces that transcend the individual
- Looked for a stronger connection with God/ a Spiritual Being.
- Sought a stronger spiritual connection with other people.
- Thought about how my life is part of a larger spiritual force.
- Tried to experience a stronger feeling of spirituality.

5. Spiritual Discontent: expressing confusion and dissatisfaction with God's/ a Spiritual Being's relationship to the individual in the stressful situation
- Wondered whether God/ a Spiritual Being had abandoned me.
- Felt angry that God/ a Spiritual Being was not there for me.

6. Marking Religious Boundaries: clearly demarcating acceptable from unacceptable religious behavior and remaining within religious boundaries
- Avoided people who weren't of my faith.
- Stayed away from false religious teachings.

D. Religious Methods of Coping to Gain Intimacy with Others and Closeness to God

1. Seeking Support from Clergy or Members: searching for comfort and reassurance through the love and care of congregation members and clergy
- Looked for spiritual support from clergy.
- Asked others to pray for me.

2. Religious Helping: attempting to provide spiritual support and comfort to others
- Prayed for the well-being of others.
- Tried to give spiritual strength to others.

3. Interpersonal Religious Discontent: expressing confusion and dissatisfaction with the relationship of clergy or members to the individual in the stressful situation
- Felt dissatisfaction with the clergy.

E. Religious Methods of Coping to Achieve a Life Transformation

1. Seeking Religious Direction: looking to religion for assistance in finding a new direction for living when the old one may no longer be viable
- Asked God/ a Spiritual Being to help me find a new purpose in life.

2. Religious Conversion: looking to religion for a radical change in life.
- Looked for a total spiritual reawakening.

3. Religious Forgiving: looking to religion for help in shifting from anger, hurt, and fear associated with an offense to peace
- Sought spiritual help to give up my resentments.

Religion, Spirituality and Cancer

Clearly there are many studies examining the impact of religion on the psychological as well as physical well-being of cancer patients. I focus, in the following, on some of them to give the reader an overview of the research field in question.

As studies show (McCrae 1984; Shrimali & Broota 1987; Spilka et al. 1983), religious resources can be particularly helpful when people are dealing with situations of severe stress that involve an element of personal threat or loss. Musick et al. (1998:218-219) mention a series of stressors for patients with cancer, among others, the possibility of death and fears associated with pain and suffering. Cancer patients also face stressors in their social life as a result of their potential inability to fulfill their normal role in the workplace or at home. Their need for assistance from others may also bring about significant feelings of tension. Regarding the stressor that cancer patients face, Johnson and Spilka (1991:21) stress that:

> Perhaps nowhere is misery greater than when an individual contracts cancer. Potential terminality becomes a salient issue, along with expectations of pain, anguish and suffering. Physical problems are compounded with a host of psychological difficulties, not the least of which are feelings of isolation, separation, dependency, and helplessness.

One of the resources thought (Jenkins & Pargament 1988; Heim et al. 1993; Gall et al. 2000) to help patients deal with the stress and tension often accompanying cancer is religious behavior. Cancer not only brings about stressors for patients, but a diagnosis of cancer also evokes a patient's ultimate existential and spiritual concerns. Such being the case, there is a chance that patients will turn to religion in coping. The availability or non-availability of religion, related to personal, situational and social factors, plays, as mentioned, an important role in this relation. There are certainly other factors that, as explained before, may influence the use of religion in coping.

Researchers have tried to examine the links between religion and cancer (Cotton et al. 1998; Heim et al. 1993; Krause 1993). Gall et al. (2000:22) maintain that:

> religious and spiritual factors or both have been related to various aspects of adjustment to cancer, including self-reported physical well-being (Highfield, 1992), general quality of life, and a fighting-spirit coping style (Cotton et al., 1998), decreased anxiety (Kaczorowski, 1998), increased hope (Mickley, Soeken & Belcher, 1992), and greater satisfaction with life (Yates et al. 1981).

On the basis of their research on "Religious Resource in Long-Term Adjustment to Breast Cancer" as well as other research on this area, Gall et al.

(2000) outline a variety of functions in the process of adjustment fulfilled by a religious or spiritual belief system. These functions are as follows:

> First, a positive relationship with God that embodies a sense of self-acceptance, belongingness, and attachment may provide a source of emotional comfort to an individual faced with a stressful and threatening circumstance (Burkhardt, 1994).… Second, it may be that in addition to providing comfort, this attachment or connection to an ultimate other or to a force greater than oneself may help to preserve or buttress a person's self-esteem and sense of personal control or efficacy (Jenkins & Paramagnet, 1995).… Third, religious and spiritual beliefs may provide a guiding framework for how the individual will perceive and approach a stressful situation (Jenkins & Pargament, 1995).

It is maintained by several researchers (Musick et al. 1998, Grosseholtforth 1996) that the religious and spiritually oriented coping strategies are, perhaps, the most beneficial strategies for people with cancer. Only a few empirical studies, however, have examined the role of religion and spirituality in coping with cancer and how such coping can be integrated into the psychosocial care of patients (Acklin et al. 1983; Johnson & Spilka 1991; Koenig 1994; Grosseholtforth 1996; Gall et al. 2000). The findings of these studies have been, however, diverse and inconsistent. For instance, while Acklin et al. (1983) as well as Koenig et al. (1988a) have not found a significant relationship between religiosity and cancer, in studies conducted by Gardner and Lyon (1982) and Mayberry (1982), a lower rate of cancer was found among various religious groups. In a study of 1000 hospitalized veterans, religious coping was no more common among patients diagnosed with cancer than among those diagnosed with other illnesses (Koenig 1994).

Despite such inconsistency, there is a strong hypothesis that religiosity and spirituality may affect the subjective well-being[4] of patients with cancer (Koenig 1995; Musick et al. 1998; Ellison 1991) and may constitute useful resources when patients are coping with their illness (Pargament 1997). On the other hand, as mentioned before, religion has its darker side and therefore can bring about certain problems, especially for people who suffer from serious illness. There are several examples of cases in which some patients, due to their religious beliefs, have refused treatment, e.g., operations, blood transfusions or chemotherapy. The religious objection to treatment has been especially problematic when parents, due to their religious conviction, object to hospital staff providing certain treatments for their child (see for instance an article written in 1997 by the Committee on Bioethics of the American Academy of Pediatrics). In certain cases, the problem has been so serious that the staff have asked the courts to intervene (see, e.g., Sevigny 2005).

Regarding the different hypotheses on the impact of religion and spirituality on health (both negative and positive), there is a need for more research in this area. Despite the importance of such studies on religious and spiritu-

ally oriented coping strategies for different diseases, among others cancer, I have been unable to find, as mentioned before, any study investigating, on the basis of a population-based survey, the different religious coping methods used among ailing persons in Sweden. There are, however, a few Scandinavian studies that have partly addressed the issue of religion and illness:

In the field of psychology of religion, one qualitative study (Lundmark 2002) was conducted among 16 cancer patients in Sweden. The study aimed at investigating the expression and function of prayers of believing Christians with cancer regarding: a) the importance prayers can have for believing Christians when coping with the physical, psychical and spiritual aspects of having a cancer disease and b) the possible interdependence between prayers and changes in life situation caused by cancer. The results show interdependence between prayer and life situation. According to this study, prayer is of great importance in coping with different aspects of having cancer. The informants have used prayers as preserving coping methods when dealing with cancer, while prayers also function reconstructively when dealing with negative coping outcomes.

Another study conducted by Ekedahl (2002) focused on the existential aspects of stress, religion and health. The objective was to study how hospital chaplains handle existential confrontation in their daily work. The study included Pargament's coping theory supplemented with Scandinavian psychology of religion research on existential questions. The empirical material consisted of interviews conducted using a life story approach. This investigation identified various types of stress/stressors namely, physiological, psychological, social, ethical and material. An existential dimension was identified within stress. Hospital chaplains applied a great number of coping methods in order to deal with the work-related stress.

In a study on spiritual healing among Norwegian hospitalized cancer patients and on patients' religious needs and preferences of pastoral services (Risberg et al. 1996), the use of "alternative medicine", here called non-proven therapy (NPT), was examined. This study was a questionnaire-based study. Among the 911 invited patients, 642 (70.5%) were included in the analysis. Spiritual healing, defined as faith healing and healing by hand, was the most frequently used NPT among Norwegian cancer patients. As the findings of this survey show, elderly female patients who used faith healing more often described themselves as religious. One hundred and thirty-nine (23%) of the responding patients reported a strengthening of their religious belief after the diagnosis of cancer.

In another Norwegian study (Torbjørnsen et al. 2000) conducted in 1995, 107 survivors of Hodgkin's disease answered 45 questions related to religion and belief, view of life, quality of life and the relation between religiosity and illness. Thirty-eight percent had changed their religious belief, 33 percent of them becoming more religious. Fifty-eight percent had prayed to God

(or a supreme being) for a cure. The study indicates that cancer activates religiosity, and that religiosity may help patients cope with their disease.

Although the above-mentioned studies touch upon the issue of religion and illness, it is not incorrect to maintain that, in general, the role (both negative and positive) of religion in dealing with cancer has been not taken into consideration in the Scandinavian countries. Among other reasons, this is because, as will be discussed in Chapter 4, the role of religion in the life of Scandinavian people is very limited, and religion does not occupy an elevated position in the sociocultural structure of Scandinavian society.

There is no doubt that the view of self and the surrounding world influences how people face their illness. Culture and ways of thinking constitute, therefore, one of the most important factors in determining the choice of coping methods. In studying the role of religion and spirituality in coping with cancer in Sweden, as an example of a society where religion plays a limited role in people's lives, we thus need a cultural approach. I have tried, through this book, to meet this need. In Chapter 4, I will discuss, from a cultural perspective, the view of religion and spirituality among Swedes, but let me first present and introduce a discussion on some definitions of religion and spirituality.

Notes:

[1] Although Judaism is one of the most important Abrahamian religions and has enormously influenced other religions, such as Christianity and Islam, it is not regarded a world religion. This is because Judaism has never claimed to be the religion of all people around the world, but only of the Jewish people.

[2] In Pargament & Mahoney (2005) and in my text, the term object "is not restricted to interpersonal objects as is customary in object relations theory. Rather is used more broadly to refer to any aspect of life" (Pargament & Mahoney, 2005:25).

[3] Both citations are from a table showing the scales of three Styles of Religious Coping (Pargament 1997:181).

[4] Subjective well-being concerns how a person decides whether his or her life is worthwhile. Judging self well-being depends on life satisfaction, satisfaction with important life areas (e.g., work), experiencing many pleasant emotions and moods, and low levels of unpleasant emotional experiences (Diener, 2000:33). In other words, subjective well-being (SWB) refers to how people evaluate their lives, and includes variables such as life satisfaction and marital satisfaction, lack of depression and anxiety, and positive moods and emotions. The idea of SWB or happiness has intrigued thinkers for millennia, although it is only in recent years that it has been measured and studied in a systematic way. A person's evaluation of his or her life may be in the form of cognitions (e.g., when a person gives conscious evaluative judgments about his or her satisfaction with life as a whole, or evaluative judgments about specific aspects of his or life such as recreation) Diener et al. (1997).

Chapter 3: Religiousness and Spirituality

This chapter focuses on some definitions of religion/religiousness and spirituality. After presenting a range of definitions and introducing a few discussions on the differences some scholars see between these two phenomena, I will present my own working definitions of religion and spirituality for the purpose of this study.

First of all, I should explain that there would appear to be four, rather than two, terms that are relevant to the discussion on religious and spiritually oriented coping: Religion, religiousness, spirit and spirituality. As Miller and Thoresen (2003) discuss, religion is commonly characterized as an institutional, material phenomenon, and religiousness is often depicted in terms of individual belief or practice. Likewise, spirit as an external transcendent or internal animating force can be differentiated from spirituality, a sacred human activity. More appropriately, religion should be compared to spirit and religiousness to spirituality. I prefer to use the term religiousness when it stands in comparison with spirituality. This also because, in my study, I focus on a multidimensional and complex construct that refers not only to institutional or material phenomena, but that also depicts individual beliefs and practices. However, because in the field of religious and spiritually oriented coping it is mainly religion and not religiousness that has been focused on, in this chapter I have also focused on the definition of religion, but naturally without overlooking religiousness. Particular attention is paid to religiousness when I discuss the alternative definitions that Zinnbauer and Pargament (2005) present. In their article, they use the word religiousness and not religion when making comparisons with spirituality.

For the past 100 years, work conducted in the social sciences has examined the phenomena of religion and spirituality. Early inquiries were also conducted within the field of psychology by scholars such as William James (1902/1961), Edwin Starbuck (1899), G. Stanley Hall (1904) and George Coe (1916). Particularly at the turn of the 21st century, the relationship between religion, spirituality and health has been seriously taken into consideration and was the focus of the January 2003 edition of American Psychologist. But despite the considerable increase in knowledge in this field, we can hardly speak of a consensus among scientists regarding the definition of religion and spirituality.

Although religion and spirituality are usually regarded as important coping resources, religious and spiritually oriented coping strategies have not

been taken into consideration until the past few decades. In addition to the antipathy toward religion inherent in the modern scientific world-view, one factor keeping research from seriously dealing with religion and spirituality in relation to coping is the problem of defining religion/religiousness and spirituality and of operationalizing them. Because the study presented here focuses on religious and spiritually oriented coping methods, it is necessary to define these two terms. Yet first, let me introduce some of the most important definitions of religion and spirituality.

Definitions of Religion

Definitions of religion have ranged from "a system of beliefs in a divine or superhuman power, and practices of worship" (Argyle & Beit-Hallahmi 1975) to "Feelings, acts and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine" (James 1961:42). Religion is regarded as that part of religiosity that is determined by persons and institutions that wield power over the individual. Religion may be ordained by Church or State. In a study conducted by Jenkins and Pargament (1995:52), religion refers to an "organized system of belief and practice such as those found in formal denominations (e.g. Catholic, Jewish, Protestant, Moslem, Buddhist) or recognized systems of theological ideas (e.g. Calvinistic, Protestant, Evangelical Christian)".

   Although religion is usually described as a framework for a system of beliefs and as being the external practice of spiritual knowledge, there are certain substantive definitions of religion that are intended to characterize it in accordance with the intrinsic qualities that religious experiences have for those who practice it. Proceeding from this perspective, religion is defined as those claimed experiences that individuals perceive as extraordinary, transcendent and clearly different from the quotidian reality perceived most of the time. Experience in these circumstances, however, is thought by some scholars, e.g. Berger (1974), to be as undeniable and more real than that which is perceived in the everyday world. Berger (1974:130-131) says:

> In the context of religious experience, the reality of daily life loses in dramatic form its status as supreme reality. It appears, to the contrary, as the anteroom of another reality, one of a drastically different nature and nevertheless of immense importance for the individual. Through this change in this perception of reality all worldly activity of quotidian reality is seen as radically reduced in importance, trivialized—in the words of Ecclesiastes, reduced to vanity.

In the contemporary social sciences, religion is defined in an analytic manner, that is, religion is characterized by the different ways in which it mani-

fests itself. From this perspective, it is supposed that there is considerable consensus among all religions regarding the forms through which the religious person may express her/his religiosity. Based on such a consensus, it becomes possible to establish the aspects that constitute such religiosity.

These aspects include:
- Sharing the beliefs that constitute the body of doctrine of the group;
- Participating in rituals and acts of devotion;
- Experiencing direct contact with ultimate reality;
- Acquiring religious information;
- Experiencing changes or results in quotidian life derived from the other aspects of religiosity.

Some researchers have approached a definition of religion that distinguishes it from other systems of meaning. For instance, Glock and Stark (1965) differentiate between the "humanist perspectives" and religions. According to them, humanist perspectives attempt to make significant the life of man. Religions, in contrast, assert that they have identified or established paths that lead to discovery of the true meaning of life. Actually, in the case of the humanist perspectives, one aims to grant to life a meaning that is agreed upon and relatively free-willed. While in the case of religions, it is presumed that life has a meaning pre-existent to that which individuals wish to give it. On this subject, Bibby (1983:103) says:

> Religious perspectives imply the possibility that our existence has a meaning which precedes that which we as human beings decide to give it. By contrast, the humanist perspective leaves to one side the search for the meaning of existence in favor of a new preoccupation with giving meaning to existence.

As the above-mentioned definitions indicate, religion is a complex phenomenon that can be defined in different ways and from different perspectives. One of the problems involved in introducing religion as a factor in medical and sociological research concerns the way in which it is operationalized.

There are, however, certain methods that have allowed socio-medical researchers to comparably successfully operationalize religion. There are both one-dimensional and multidimensional measures of religion.

In some research on religion and health (Levin & Schiller 1987; Larson et al. 1986), religious affiliation is the most commonly used measure of religion. Regarding this kind of measuring of religiousness, as Williams points out, the question of how to group different denominations that share common characteristics has received extensive attention from sociologists of religion. The distinction between church and sect is one of the most influential typologies in the field. This kind of measurement is, however, inade-

quate and does not capture the great variations that exist among religious groups (Williams1994:127).

The frequency of religious attendance is another one-dimensional measure of religion used in health research (Larson et al. 1986; Levin & Shiller 1987). There are, however, certain problems associated with the use of religious attendance as a measure of religious involvement: among others, the fact that religious attendance "is frequently a badge of social status, secular in character, and of no greater religious significance than participation in other community organizations" (Williams 1994:129). Another problem is that, as research (Levin & Markides 1986) on elderly people shows, public participation in religious activities requires a certain degree of physical health. Furthermore, it is not clear that religious attendance per se is indicative of anything intrinsically religious. Considering the fact that among elderly the intrinsic dimension of religiosity is often stronger than the extrinsic dimension, this problem becomes more serious.

In order to capture the quality of the impact of religious rituals as well as symbolism on people's health, especially when dealing with a serious illness, what is needed is a comprehensive but parsimonious set of conceptually based measures of religious involvement. In research on religious coping strategies, a multidimensional conceptualization of religious involvement, based on profiles of religious sentiments, and activities as well as differential sociodemographic factors are of tremendous importance.

The use of multidimensional measures of religious involvement becomes still more essential when a sociological approach is to be applied. There are, however, different types of multidimensional measures of religious involvement. The Index of Religiousness and Glock's multidimensional measurement model of religion are among the most important ones.

The Index of Religiousness (Zuckerman et al. 1984) contains a three-item measure asking about the frequency of attendance at services, perceived religiousness and the degree to which religion is a source of comfort.

Glock's multidimensional measurement model of religion (Glock & Stark 1965) is another multidimensional measure. Glock and Stark (1965) have devised a scale for measuring religiosity based on five dimensions of religion: Experiential (religious feelings), ritualistic (religious practice), ideological (religious beliefs), intellectual (religious knowledge) and a fifth dimension called consequential (generalized effects of religion on an individual's life). The latter dimension examines how the first four are applied in real life.

As a concept applicable to individuals, religiousness is composed of both internal and external dimensions. Internally, people may have religious identities, goals for religious development, and religious attitudes, values and beliefs. The psychological salience of religious ideas and behavior varies enormously across individuals and across cultures. Externally, religiousness

can be expressed by religious affiliation, devotional practices, membership in a religious community or attending religious functions.

King et al. (1994:632) describe religion as the external practice of spiritual knowledge and/or the framework for a system of beliefs, values, codes of conduct and rituals. Thus, religion may be regarded by some people as synonymous with spirituality, while for others spirituality may be a broader term including the behavioral, cognitive and organizational elements of religion, but encompassing broader, more mystical experiences as well. Let us, in the following, discuss how spirituality is conceptualized in the field of religion and health.

Definitions of Spirituality

The term "spiritual" may be considered to relate to the search for the existential meaning of any life experience (Hungelmann et al. 1996; Burkhardt 1993; Emblen 1992). Spirituality may refer, on the other hand, to a belief in a "higher power" outside oneself that may influence a person's life. This higher power may or may not be referred to using the word God (Hungelmann et al. 1996; Foley et al. 1998). Emphasizing this distinction is important in an inquiry into the religious and spiritually oriented coping methods used in societies where people are more spiritual than religious. Those who are spiritual do not always describe themselves as religious.

Spirituality points to an element of transcendence, of meaning in life and a concept of self that goes beyond societal expectations or definitions. Dudley and Helfgott (1990:287) speak of the spiritual dimension as "[encompassing] the need to find satisfactory answers to the meaning of life, illness, and death, as well as seeking a deeper relationship with God, others, and self". Seen in this light, spirituality is different from religion, which is related to a particular social institution. Spirituality, as Pastorello and Wright (1997) stress, does not necessitate association with a formal religion.

Summing up, definitions of spirituality are diverse. Spirituality has been defined as "the human response to God's gracious call to a relationship with himself" (Benner 1989:20), "a subjective experience of the scared" (Vaughan 1991:105) and "that vast realm of human potential dealing with ultimate purposes with higher entities, with God, with love, with compassion, with purpose" (Tart 1983:4).

Concerning the relation between religion and spirituality, spirituality is, according to Scott (1998:5), an inclusive word, a dimension within every person, integrating all of life and giving life meaning: It is not, then, to be confined to formal religious observance. Scott (1998:7) defines spirituality as that which motivates all of life, enhances the spirit and gives life overall meaning and purpose. Forbes (1994:297) points out that spirituality encompasses, but is not limited to religiosity. According to Moffitt (1997), spiritu-

ality can be understood as a search for the meaning of life, and religion as one way of conducting this search. Generally, spirituality is conceptualized as an orientation to life and death, as that which provides meaning in life. In other words, religion can be seen as "the doing and spirituality as the being" (ibid.). Seen in this light, the difference between religiously directed individuals and spiritually directed individuals is that while the first group "use their religion" (i.e., are extrinsically oriented), the second group "live their religion" (are intrinsically oriented) (Allport & Ross 1967:434). Although the distinction between spiritual and religious is vague, it is generally supposed that spirituality has been likened to intrinsic, as opposed to extrinsic religiosity, assuming some sort of continuum. Allport's distinction between intrinsic and extrinsic religious orientation is grounded on the Weberian approach to religion. According to Weber (1964), what makes religion consequential for human behavior is the meaning provided by religious ideas. In this regard, he distinguished conceptions of the supernatural based on taboo from those based on religious ethics. While the former focus on the perception and proscription of behavior, the latter involve a more general orientation toward all aspects of life and social relationships. In line with the Weberian approach, Allport distinguishes between intrinsic religion, which according to Williams (1994:139) is an internalized, all pervasive, organizing principle, and extrinsic religion, which is external and instrumental, a tool used to provide needs such as status and security. According to Allport and Ross (1967:434), we observe "intrinsic" religiosity among those who find their master motive in religion, persons for whom other needs, strong as they may be, are regarded as having less ultimate significance, such that they are brought into harmony with their religious beliefs. "Extrinsic" religiosity can be seen among those who use religion for their own needs, persons whose values are instrumental and utilitarian (ibid.).

When dealing with the relation between religion, spirituality and health, an important task, in addition to the operationalization of religiosity, is the operationalization of spirituality. Spirituality is a multidimensional phenomenon and may be observed or expressed through a variety of behaviors.

Some Problems Associated with the Measurement of Religion and Spirituality

One of the most serious problems associated with many measurements is the use of various global indices of religious involvement, such as denominational affiliation or frequency of church attendance. Koenig et al. (2001), in a review of 101 studies concerning the association between religion and spirituality and mortality, considered that half of the reviewed studies (n=47) measured religion and spirituality as religious affiliation only (Hill &

Pargament 2003:66). One of the problems of such measures is that, as Hill and Pargament point out (ibid.), they may not uncover the possible harmful health effects of religion and spirituality.

The other problem is that they leave unanswered critical questions about why and how religion and spirituality influence health. Although we have witnessed, during the past decade, advances in measures of religion and spirituality in the psychology of religion through inclusion of, e.g., cognitive, emotional, behavioral, interpersonal and physiological dimensions, much of this empirical work has not been properly integrated into inquiries relating religion and spirituality to health (Hill & Pargament 2003:66). According to Hill and Pargament (2003:66), one reason is that health researchers are not well acquainted with the psychological study of religion, perhaps because much of the research has been published in specialized journals.

Another problem is that measures of religion and spirituality have been mainly aimed at certain groups, especially members of the Judo-Christian traditions. Other religious groups, such as Muslims and Hindus, have rarely been studied. Moreover, the non-theists and atheists have been largely left out of the realm of such measurements. Measures of religion and spirituality suffer deeply from lack of sensitivity to cultural characteristics issues, and the social differences between individuals have been neglected. As Hill and Pargament (2003:70) point out, "those studies that overrepresented Protestants in the United States have also overrepresented Whites, the middle-class, and, to some extent, men".

Thus, it is vital that the conceptualization and measurement of religion and spirituality reflect greater sensitivity to cultural characteristics and extend beyond the Judo-Christian population, especially to non-American populations as well as to non-Western religious and spiritual traditions. Moreover, such conceptualizations should grow in size and sophistication, taking into consideration dimensions of religion and spirituality other than those used in global indices.

There are very few measures that are more contextually sensitive to the manifold dimensions of religion and spirituality. A very well-proven measure, which shows more sensitivity to different aspects of religion and spirituality and therefore covers several ranges of religious and spiritually oriented coping methods, is the Measure of Religious Coping (RCOPE). In Chapter 2, a detailed explanation of RCOPE was presented. We learned that this measure has two dimensions: positive religious coping and negative religious coping, each containing 5 items. Specific religious coping methods were defined for each of these religious functions, and subscales were created. Not merely based on the global indicators of religiousness (e.g., frequency of prayer, congregational attendance), RCOPE also focuses on how the individual is making use of religion to understand and deal with stressors. As it seems, RCOPE, in comparison with the other ways of operationalizing religion and spirituality, is suitable for a more comprehensive assess-

ment of religious/spiritual concerns, in quantitative as well as qualitative studies. Above, I introduced definitions of religion and spirituality in different sections as though they were separate from each other, however, there is disagreement between scholars on this separation. Because the relationship between religion and spirituality is regarded as important in my study, in the following, I will present some approaches to the issue of the separation of religion and spirituality.

Religion and Spirituality: Separate or Not?

There are different approaches to studying religion and spirituality as well as their functions and meanings in individuals' lives. Zinnbauer et al. (1999:899) divide these approaches into the categories traditional and modern. Zinnbauer et al. (1999:899) maintain that the most important difference between the traditional and modern approaches is that the modern approaches consider a polarization between religion and spirituality. Differences between these two approaches, as Zinnbauer et al. (1999:899) discuss, can be summarized as follows: While the traditional approach regards religion as a broadband construct, the modern approach sees religion as a narrowly defined construct. In the traditional approach, spirituality is not widely differentiated from religion; in other words, religion and spirituality are not polarized. In the modern approach, spirituality is explicitly differentiated from religion, i.e. religion and spirituality are polarized. While the traditional approach emphasizes personal religiousness, in the modern approach external, instrumental religion is contrasted with personal, relational spirituality. In the traditional approach, religion includes substantive functional elements. In the modern approach, substantive religion is contrasted with functional spirituality. The traditional approach regards religion as positive and negative. The modern approach views religion as negative and spirituality as positive.

In the following, I will discuss some of these characteristics when these two approaches are presented.

Traditional and Modern Approaches

Regarding the traditional approach, some researchers, as Zinnbauer et al. (1999:897) mention, proceed from a substantive perspective when defining religion. Here the focus is on emotions, thoughts, behaviors, relationships, etc. Argyle and Beit-Hallahmi's (1975:1) definition of religion indicates this approach: Religion is defined by them as "a system of beliefs in a divine or superhuman power, and practices of worship or other rituals directed towards such a power".

Another traditional approach involves understanding religion from a functional perspective. The following definition of religion captures this approach: "Beliefs, emotions, practices, and experiences are examined, but the focus is on how they are used to deal with the fundamental problems of existence such as meaning, isolation, suffering, and injustice" (Baston et al. 1993).

Emphasis on personal aspects of religiousness is another traditional approach to religion. Individuals' behavior, cognitions, affects, experiences and motivation, as Zinnbauer et al. (1999:898) point out, are in focus in this approach. An example of this approach is reflected in William James' (1961:42) definition: "the feelings, acts, and experiences of men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine".

Another approach categorized as traditional is the recognition that religion may have a positive as well as a negative side. For example, Fromm (1950) regarded a contrast between an authoritarian religion and a humanistic religion, in the former people demean themselves in relation to a greater power, while in the latter God represents and empowers individuals' strength and self-realization. Allport's (1966) differentiation between intrinsic religion and extrinsic religion, explained above, is in the same vein. Zinnbauer et al. (1999:898) explain this as follows:

> The intrinsic believer for Allport "lives" his or her religion and views faith as an ultimate value in itself. In contrast, the extrinsic believer "uses" religion in a strictly utilitarian sense to gain safety, social standing, or other secular or anti-religious goals.

Regarding the modern approaches, as mentioned, Zinnbauer et al. (1999:898) recognize a tendency toward the polarization of religion and spirituality. One of the earliest attempts to differentiate religion from spirituality is found in Maslow's (1964:12) suggestion that concepts such as values, ethics, spirituality and morals should be "taken away from the exclusive jurisdiction of the institutionalized churches". According to Zinnbauer et al. (1999:900), the development of a conceptual model of spirituality (Helminiak 1987; LaPierre 1994) and of the different measures (Kaczorowski 1998; Lindgren & Coursey 1995) aimed especially at spirituality indicates such a tendency toward separating religion from spirituality.

Another tendency is that:

> Many functional descriptions formerly attributed to religion are now invoked to characterize spirituality. Spirituality has come to represent whatever people do to attain a variety of goals, such as meaning in life, wholeness, interconnection with others, truth, and one's own inner potential (Zinnbauer et al. 1999:902).

Examples of such an approach can be found in Goldberg's (1990) description of spirituality as a search for universal truth or Mauritzen's (1988:118) depiction of spirituality as "the human dimension that transcends the biological, psychological, and social aspects of living".

Another issue concerning the modern approaches to religion is that, according to Zinnbauer et al. (1999:901), "Scholars are distinguishing the 'organized,' 'social', and 'traditional' beliefs and practices of religion from the 'personal," 'transcendent' and 'relatedness' qualities of spirituality". An example of such an approach can be found in Emblen's (1992:45) definition of religion as "a system of organized beliefs and worship which a person practices," and spirituality as "a personal life principle which animates a transcendent quality of relationship with God".

Regarding religiousness as negative and spirituality as positive is also a tendency that Zinnbauer et al. (1999:902) identify in the modern approaches. Illustration of this tendency can be found when Tart (1975:4) stresses that the term religious, "implies too strongly the enormous social structures that embrace so many more things than direct spiritual experience." For him religion is associated with "priests, dogmas, doctrines, churches, institutions, political meddling, and social organizations," while the term spiritual "implies more directly the experience that people have about the meaning of life, God, ways to live, etc."

Zinnbauer et al. (1999) criticize, on the one hand, the traditional approaches for not distinguishing between religion and spirituality and, on the other, the modern approaches for polarizing these two phenomena, thereby presenting only a limited understanding of the two constructs. The need is therefore to distinguish between the constructs without polarizing them. To meet this need, Pargament (Zinnbauer et al. 1999) has proposed an alternative approach. Because I have partly proceeded from Pargament's model of religious coping, RCOPE, I will present his approach and then introduce my own view.

An Alternative Approach

Definition of Religion

Pargament defines religion as "a search for significance in ways related to the sacred". This definition is based on a "goal-related view of human nature" (Zinnbauer et al. 1999:907). The assumption is that "people are proactive, goal-directed beings searching for whatever they hold to be of value in life. Every search consists of a pathway and a destination" (Pargament & Mahoney 2005:181). Two key concepts are essential in this definition: significance and the sacred. Because I will use these two concepts in analyzing the findings of my study, I present in the following the meaning and functions of these concepts based mainly on Pargament's discussion of them. In

addition, this presentation is important to understanding how my own definitions of religiousness and spirituality differ from the others.

Significance means here a wide range of things that may be important to the individual, institution or culture (Pargament 1997:31). According to Pargament (1997), significance is, in part, a phenomenological construct. It involves the experience of caring, attraction or attachment. Significance is, according to Pargament and Mahoney (2005:181), both subjective and objective:

> Subjectively, significance involves the sense of satisfaction, value, and importance that accompanies the pursuit and attainment of goals. Objectively, significance refers to the goals that people strive for in living. People may pursue objectives that have psychological (e.g., a sense of power), social (e.g., intimacy with others), physical (e.g., health), material (e.g., a nice house), as well as spiritual characteristics.

In the same vein, Pargament (1997:92) points out three properties of significance: subjective, objective and motivational. The subjective property is described in terms of feelings. This means that:

> Significance is, in part, a phenomenological construct involving feelings and beliefs associated with worth, importance, and value. It embodies the experience of caring, attraction, or attachment…Significance is, in the words of William James (1902:193) "the hot place in consciousness" (Pargament 1997:92).

Significance is, however, more than a phenomenological experience, Pargament (ibid) stresses. It is also object oriented. Pargament (1997:92) mentions that:

> We care *for*, we are attracted *to* something. We might call these somethings, whatever they are, objects of significance or even "significants." The concept of significance calls our attention not only to the sense of significance, but to the objects of significance as well…. Shaped by culture and experience, or generated through a more creative process, people can come to value a virtually limitless set of significant objects (Klinger, 1977; Rychlak, 1981). They may be material (e.g., money, food, cars, houses, drugs, or weapons), physical (e.g., health, fitness or appearance), psychological (e.g., comfort, meaning, growth), social (e.g., intimacy, social justice), and/or spiritual (e.g., closeness with God, religious experience).

That the search for significance is necessary for a productive life does not mean, as Pargament (1997:93) points out, that everything we search for is necessarily good for us. However, significance, "be it constructive or destructive," has motivational properties people are drawn to.

Pargament (1997:95) views the search for significance as "the overarching guiding force in life, one that directs people along very different paths".

This search has no universal objects. Significance, according to Pargament (1997:31), includes life's ultimate concerns, possibilities that are far from universal and may be good or bad or tangible possessions such as money, houses, good looks or drugs. For some people, significance is defined "in terms of personal well-being, be it peace of mind, meaning in life, personal growth, physical health, or the avoidance of pain" (ibid.). Significance may focus on intimacy with others or the desire to make the world a better place (ibid). Significance may also be defined in terms of the sacred (ibid). It is precisely at this point that religion in coping enters the scene. According to Pargament (1997:31-32):

> how we find or build significance, how we hold on to it, and how we transform it when necessary are issues of great religious importance. In short, the search for significance is another essential point of religious reference.

Although significance is, according to Pargament (1997:32), a necessary element of religion, it is not, in and of itself, religious. It becomes religious only after it has been invested with a sacred character. Pargament points out that different responses of an individual to a painful situation are not "necessarily 'religious' unless we stretch the meaning of the term beyond recognition. The experience becomes religious only when the sacred is woven into the person's aspirations and responses" (ibid), in other words, when the situation is viewed as an opportunity to get closer to God, when the congregation becomes a source of emotional support, when God is blamed for the loss, or when the Bible is read as a way to soothe the pain of the problem we have faced (ibid).

The choice of significant objects is not trivial. Referring to Emmons' (1999) study, Pargament maintains that the characteristics of the goals people seek in life have important implications for their well-being.

As we have seen above, the sacred has an important place in Pargament's definition of religion. Referring to the definition of sacred in the Oxford English Dictionary, Pargament (Zinnbauer et al. 1999:907) stresses that it refers to "the holy, those things that are 'set apart' from the ordinary and deserving of veneration and respect." The sacred "includes concepts of God, the divine, Ultimate Reality, and the transcendent, as any aspect of life that takes on extraordinary character of its association with or representation of such concepts" (Hill & Pargament 2003:65). But his definition goes beyond this. Pargament (Zinnbauer et al. 1999:910) emphasizes that, as Durkheim (1915:52) stated, "by sacred things one must not understand simply those personal beings which are called Gods or spirits; a rock, a tree, a spring, a pebble, a piece of wood, a house, in a word, anything can be sacred". According to Pargament (Zinnbauer et al. 1999:911), "Virtually any object or attribute can be imbued with divine qualities". Such being the case, although the sacred is not limited to a higher power, it also includes "objects

that become sanctified by virtue of their association with, or representation of, the holy" (Zinnbauer et al. 1999:907).

Pargament (Zinnbauer et al. 1999:908) identifies several classes of objects:

> time and space (the Sabbath, churches), events and transitions (birth, death), materials (crucifix, wine), cultural products (music, literature), people (saints, cult leaders), practices (prayer, tithing), psychological attributes (self, meaning), social attributes (compassion, patriotism), and roles (marriage, parenting, work). We can also speak of sacred means and sacred ends. When an individual seeks out a sacred destination in life, or takes a pathway that is somehow connected to the sacred, we describe that individual as religious.

Pargament's view of the sacred is not only important to the way in which religion is defined, but also to the way we understand religious and spiritually oriented coping. This is because, in religious and spiritually oriented coping, an essential issue is how people perceive certain phenomena as well as certain aspects of their life as being sacred.

The process through which things turn out to be sacred – sanctification – is a critical, but "a neglected construct in the psychology of religion" (Pargament & Mahoney 2005:182), which thus needs to be taken into consideration when defining religion and spirituality and operationalizing them in order to apply such operationalizations to the study of coping methods.

Although the term sanctification has specific theological meanings, Pargament and other scholars have tried to define sanctification using a scientific and non-theological approach. In an earlier definition (Mahoney et al. 2003; Pargament 1999), sanctification is defined as "a process through which seemingly secular aspects of life are perceived as having spiritual character and significance" (Pargament & Mahoney 2005:182). But these researchers, having realized that this "definition may be overly broad, since sanctification could be applied to the demonic as well as the sacred" (Pargament & Mahoney 2005:183), have refined their definition to make it more precise. In the new definition of sanctification, the term "spiritual" is replaced with the term "divine". The new definition refers then to sanctification "as a process through which aspects of life are perceived as having divine character and significance" (ibid.). Despite such a replacement, the process of sanctification is not limited, according to Pargament and Mahoney (2005:185), "to theistically oriented interpretations of various aspects of life". Sanctification can occur both directly and indirectly; that is, "aspects of life may be perceived both as manifestations of God and as embodiments of divine or transcendent qualities" (Pargament & Mahoney 2005:186). These sacred qualities embrace attributes of transcendence (e.g., holy, heavenly), ultimate value and purpose (e.g., blessed, inspiring) and timelessness (e.g., everlasting, miraculous) (Pargament & Mahoney 2005:185). By regarding the sacred qualities as manifestations of both God and the divine as

well as the transcendent, Pargament and Mahoney (2005:187-188) define "sanctification as a process of potential relevance not only to theists but to nontheists as well".

Encompassing two large spheres, the sacred and significance, religion can, as mentioned above, be defined as "a process, a search for significance in ways related to the sacred" (Pargament 1997:32). What is important from the viewpoint of religious coping is that this definition allows a wide range of coping methods, which have not traditionally been related to religion, to be classified as religious coping. This is because, as Pargament (ibid) maintains, both the sacred and significance can be defined in many different ways and as a result,

> this definition of religion is not overly restrictive or religiously ethnocentric. In fact, it seems open to the new and the old: evolving expressions of spirituality as well as traditional expression of faith, involvement of religious movement as well as participation in established religious traditions, and religiously based social and political action as well as personal acts of mercy and compassion (Pargament 1997:32-33).

Definition of Spirituality

Pargament's definition of spirituality is based on his view of religion, significance and the sacred. According to Pargament (Zinnbauer et al. 1999:909), spirituality is *a search for the sacred*. Pargament (Zinnbauer et al. 1999:909) emphasizes that:

> As such, spirituality is the heart and soul of religion, and religion's most central function. Spirituality has to do with the paths people take in their efforts to find, conserve, and transform the sacred in their lives. Whereas religion encompasses the search for many sacred or nonsacred objects of significance, spirituality focuses specifically and directly on the search for the sacred. As with religion, spirituality can take individual and institutional, traditional and nontraditional, and helpful and harmful forms.

Pargament (Zinnbauer et al. 1999:909) stresses that the sacred is not limited to traditional concepts of God, higher power or the divine. This does not mean that significant objects such as intimacy with others, authenticity, meaning in life, holism and self-improvement – which are valued in our time – do not fall within the spiritual realm unless they are somehow connected with the sacred. He states that many processes and objects of significance are, "in fact, often implicitly tied to the sacred but the connection must be made explicit before they can be labeled spiritual" (Zinnbauer et al. 1999:910).

What, then, is the relationship between religion and spirituality in Pargament's perspective? His own answer is that:

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From Pargament's (in press) perspective religion is a broader and more general construct than spirituality. If the sacred is involved in either a pathway or a destination then that search qualifies as religious. Thus, religion encompasses not only the search for sacred ends (spirituality), but the search for secular ends through sacred means (Zinnbauer et al. 1999:910).

Although Pargament distinguishes between religion and spirituality, he remains in the same paradigm as the advocators of the traditional approach by viewing religion as broader than spirituality and by viewing spirituality as part of religiosity. Considering the implication of spirituality for health research, Pargament (Zinnbauer et al. 1999:909) stresses that "we cannot measure whether an individual has indeed found God, but we can study the physical, psychological, and social 'footprints' left by those engaged in the search". Referring to such studies as Pargament et al. (1990) and Welch and Barrish (1982), Pargament (Zinnbauer et al. 1999:909) stresses that we can compare individuals who take different pathways toward different destinations.

During recent decades, the impact of spirituality on well-being has been the focus of several scholars, especially psychologists. Yet Pargament does not approve of their view of the sacred. He criticizes psychologists for reducing the sacred to other, supposedly more basic motives and drives and for regarding spirituality as a form of anxiety reduction, a source of social cohesion, an evolutionary advantage and so on. Pargament admits, however, that spirituality may serve these purposes "but the search for the sacred represents a legitimate right that cannot be reduced to other ends without losing its essence" (Zinnbauer et al. 1999:909).

After having introduced Pargament's approach to and definition of religion as well as spirituality, I will now comment on and criticize his view as well as present my own definitions. I realize that it is important to put forward my critique of Pargament's approach to religion and spirituality, as this approach has been important in formulating my definition of religiousness and spirituality.

Comments on Pargament's Definitions

Let us reiterate the key issues in Pargament's approach to religion and spirituality presented above.

1. Religion is *a search for significance in ways related to the sacred*.
2. Significance means *a wide range of things that may be important for the individual, institution or culture*. It may involve the sense of satisfaction, value and importance that accompanies the pursuit and attainment of goals (subjective significance) or may refer to the goals that people strive for in living (objective significance).

3. *The sacred refers to the holy*, and the core of the sacred consists of concepts of God, the divine and transcendence. The sacred also includes objects that become sanctified by virtue of their association with, or representation of, the holy.
4. Sanctification is related to those aspects of life that may be perceived both *as manifestations of God and as embodiment of divine or transcendent qualities*. For this reason, sanctification is considered a process of potential relevance not only for theists, but non-theists as well.
5. Spirituality is *a search for the sacred*. Whereas religion encompasses the search for many sacred or non-sacred objects of significance, spirituality focuses specifically and directly on the search for the sacred.

By focusing on three terms: search, significance and sacred, Pargament introduces new definitions of religion and spirituality. Although his definitions of these two terms broaden the domain of religiosity and spirituality beyond traditional concepts of God, they still remain in the realm of traditional approaches, in that they regard religion as a broader and more general construct than spirituality. Religion encompasses spirituality. Besides confining spirituality to the realm of religion, Pargament's definitions also cause certain problems when we try to apply them to the research field of religion and health. Let us first consider some of the problems associated with Pargament's definition of religion.

Pargament's definition of religion, as he himself (Zinnbauer et al. 1999:908) points out, differs from the narrow and polarized view of religious experience. It not only integrates the substantive and functional approaches into one approach, but also includes the good and bad aspects of religious life and at the same time, although distinguishing religion from spirituality, does not regard them as polarized. People's personal and social experiences are also encompassed. Religion encompasses not only the search for sacred ends (spirituality), but also the search for secular ends through sacred means (Zinnbauer et al. 1999:910). This is possible owing to his broad definition of sanctification, which is able to embrace both God, divine and transcendent qualities and is considered a process of potential relevance not only for theists, but also for non-theists. One problem associated with Pargament's definition of religion is that he fails to make a clear demarcation between what constitutes a religious pathway and what does not, as well as who is a religious person and who is not. This is because he, in his endeavor to overcome the problem of the polarization of religion and spirituality – an endeavor I find interesting from a philosophical point of view – extended the framework of the definition of religion so broadly that religion loses its divine characteristics. I will try to show this using an example from my study. My study identified several cancer patients who stressed that they do not believe in God or any other higher power, but who admitted having experienced a spiritual feeling, a kind of unity of existence when visiting natural land-

scapes[1]. Now, if we accept Pargament's perspective on religion and the sacred, we should regard these atheists' search for significance by means of the sanctification of nature as a transcendent experience of the unity of existence, a religious pathway! According to him, we should do this because we face here a "nontheistic sanctification", which means that individuals can conceivably attribute sacred qualities to significant objects even though they do not espouse beliefs in a God or higher power (Pargament & Mahoney 2005:185). And the fact that the object of significance is not directly related to God or the divine is not problematic; it is related to a transcendent quality.

Not only are the pathways of our atheists who admit to having had spiritual experiences and feelings considered religious pathways, but the atheists themselves can also be regarded as religious persons. This is because Pargament (Zinnbauer et al. 1999:908) tells us that "when an individual seeks out a sacred destination in life, or takes a pathway that is somehow connected to the sacred, we describe that individual as religious". Our atheists take pathways that are somehow connected to the sacred – here considered a transcendent quality – which in this case is an experience of unity of existence through the sanctification of nature.

The question, at this point, is whether an atheist's search for significance by means of the sanctification of nature makes him a religious person. How can we distinguish a religious person from a non-theist or even an atheist? This question has more immediate importance and becomes more crucial when we are dealing with the empirical studies. For instance, when we are studying the application of coping methods among different groups, such as the religious, non-theists and atheists, should we regard our atheists, mentioned above, as belonging to the "theist group" or the "non-theist group" or the "atheist group"? Can we ignore individuals' own understanding of their identity as a religious person or an atheist and categorize them in a way that suits our definition? It is clear that there are often discrepancies between informants' and researchers' understandings of certain definitions, but definitions, although constructions of the human mind, cannot be arbitrary. They should not be against the informants' own understanding of their affiliation with, e.g., a certain political, social, religious group. Moreover, they should be based on historical and social grounds (the religion's history and social attributes).

In my view, the fact that religion and spirituality are regarded as polarized is not merely a theoretical "problem". This polarization actually reflects the spirit of our era, when people no longer regard religion and spirituality as a united phenomenon. Some studies (Zinnbauer et al. 1997; Scott 1998) support this notion of polarization.

Pargament (Zinnbauer et al. 1999:902) points out that "religiousness and spirituality have acquired specific valences in popular and scientific writings". What he is referring to is negative religiousness versus positive spirituality (ibid.). He also reminds us that "Previously undifferentiated from

religiousness, numerous forms of faith under the label 'spirituality' have risen in popularity from the 1980s to the present" (Zinnbauer & Pargament 2005:24) and that these changes "have occurred against a background of decline in traditional religious institutions, an increase in individualized forms of faith expression, movement from an emphasis on belief towards direct experience of the sacred, and an American culture of religious pluralism" (ibid.). Thus, if the attention in research has changed from religion to spirituality, it is because, as he stresses, "Spirituality has also replaced religiousness in popular usage" (ibid.). Based on the above citations, it becomes clear that people not only differentiate between religion and spirituality, but also identify themselves as being spiritually oriented as opposed to religiously oriented. What is clear is that people in the modern era take exception to what they understand as religion and seek other sources of "sacredness". For many people, religion is associated with dogma, churches, priests, institutions and political meddling. These people are seeking something else. We cannot, by changing the definition of religion, change the historical background of religion or its social attributes. Moreover, we cannot change the fact that religion no longer attracts the same numbers of people and that people do not want to be identified as religious. This last point is very important, because in order to conduct studies in the field of religion and health, we must base our categorization of people into different groups on how they view themselves. If a person identifies her-/himself as a non-theist, we can hardly classify her/him as a theist in accordance with our definitions of these terms.

Pargament can hardly disagree with this point, as he, when referring to several studies, stresses that "individuals have clear ideas about the meaning of these terms [religion and spirituality, author's note], are able to describe their beliefs in a reliable fashion, and are able to distinguish religiousness and spirituality from other constructs and phenomena" (Zinnbauer & Pargament 2005:22).

He is also aware of the risk a researcher takes by not considering the various ways in which people relate themselves to what they regard as sacred and the way in which they identify their philosophy of life. Pargament (Zinnbauer & Pargament 2005:30) states that:

> On the other hand, should researchers define the terms in ways that are fully removed from popular uses, or in ways that narrowly exclude great sections of the religious and spiritual landscape, the legitimacy or relevance of the field may be questioned. The varieties of religious and spiritual experiences provide remarkable examples of human diversity. Universalist assumptions about the religiousness and spirituality of *all* people obscure important variations in the belief and practice of different people (Moberg 2002). At worst, they have the potential to insult or oppress minority groups.

The problem we have discussed above, regarding Pargament's definition of religion and the sacred, reflects the same problem he mentions above, i.e. removing definitions of terms from popular uses and excluding the different ways in which people express their spiritual feelings, practices that endanger the relevancy and legitimacy of the research field. This point is very important when we recall that in some countries, like the Scandinavian, people who identify themselves as spiritual but not religious, or who state that they have experienced certain spiritual feelings, but at the same time admit that they are atheists, are not in the minority (see Chapter 4).

If our approach to studying the psychology and sociology of religion, especially in relation to health, is not a theological one, but instead sociological or psychological, then we should take into consideration the changes experienced by people all around the world during the "postmodern era". We should accept that the diminishing interest in attending church and participating in divine services as well as the dissociation from religion and from God as a shepherd is a sign of development of new approaches to the self and the other, which in its turn has brought about new understandings of what are called sacred values. As Luckmann (1996) points out, we are witnessing the development of "postmaterialist values" as the sacred values of our time, which goes hand in hand with individualization. Postmaterialist values are related to contemporary humankind's need for self-actualization. The tendency toward polarizing spirituality and religiosity is not, as Pargament (Zinnbauer et al. 1999:903) maintains, due to scholars' limited understanding of religion and spirituality, rather it is a reflection of the real changes occurring independent of scholars' definitions and ideas. Pargament (Zinnbauer & Pargament 2005:27) himself stresses that "It is no coincidence that the popularity of spirituality has grown in a culture that values individualism, and risen during a historical period in which traditional authority and cultural norms were being rejected."

I agree that sometimes the polarization between religion and spirituality is naïve and simplified, and I accept that the relationship between these two phenomena is much more complicated than: "spirituality is cool, and religion is uncool", but I see serious difficulty in proceeding from Pargament's definition of religion in the research field of religion, spirituality and health without risking neglect of the informants' own understanding of their religious and spiritual feelings and lives.

The second problem associated with Pargament's discussion on religion and sanctification is that it is not clear how he differentiates the "manifestations of God", "embodiments of divine" and "transcendent qualities" from each other when he stresses "Sanctification may occur both directly and indirectly; that is, aspects of life may be perceived both as manifestations of God and as embodiments of divine or transcendent qualities" (Pargament & Mahoney 2005:186). Because Pargament's definition of religion is related to the concepts of the sacred and sanctification, it is important to clarify what

God, divine and transcendent refer to. I think the first problem, i.e. defining religion in a too broad framework, is partly due to an ambiguous view of what exactly is meant by the "manifestations of God", "embodiment of divine" and "transcendent qualities".

Grasping Pargament's understanding of God, the divine and transcendence is important not only for comprehending his view of religion, but also of spirituality. Spirituality is defined by Pargament as a search for the sacred, and the core of the sacred consists of concepts of God, the divine and transcendence.

On the one hand, Pargament defines spirituality as a search for the sacred. On the other, he stresses that the sacred refers to the holy and includes objects that become sanctified by virtue of their association with, or representation of, the holy. By relating the sacred to the holy and by replacing the term "spiritual" with the term "divine" in his new definition of sanctification, Pargament actually ensures that the sacred will remain in the framework of religiosity and consequently that spirituality will become a part of religion. This allows Pargament to overcome the problem of polarization of these concepts, as we see in the modern approaches. There are, however, some problems associated with Pargament's definition of spirituality.

If Pargament's definition of religion is too broad to allow drawing a demarcation line between religion and non-religion and distinguishing a religious person from a non-religious person, then his definition of spirituality is also too narrow to embrace many experiences that are described by nontheists or atheists as spiritual. In other words, in Pargament's definition, spirituality remains an integrated part of religion and its domain does not extend outside the framework of religion. In this way, those pathways that do not refer to the holy or are not based on a belief in God or a higher power remain outside the realm of spirituality. This may cause serious problems in empirical studies when individuals identify themselves as spiritual, but not religious and admit to following such pathways.

Another problem is that Pargament's definition of spirituality does not touch upon one of the most important dimensions of spirituality, that of connection. In all spiritual pathways, even those that focus on detachment from terrestrial life, the ultimate goal is connection with a transcendent source, a unity. The definition of spirituality as a search for the sacred focuses on the means, but not the ends. We learned earlier that, in defining religion, Pargament proceeds from a "goal-related view of human nature". This is because he supposes that, "people are proactive, goal-directed beings searching for whatever they hold to be of value in life. Every search consists of a pathway and a destination" (Pargament & Mahoney 2005:181). If this is the case, then why, in defining spirituality, is the most important goal of connection forgotten? Pargament is well aware of the importance of connection in spiritual life. Pargament (Zinnbauer & Pargament 2005) refers to studies showing that informants tend to characterize religiousness in terms of for-

mal/organizational religion, and spirituality in terms of closeness to God or feelings of interconnectedness with the world and living things. But if we accept that individuals' feelings of interconnectedness with the world and living things are spiritual feelings, then we must ask where is the "reference to the holy" here? Where can we find religion's place in this picture? Here again we have a problem with our atheists or non-theists, as in the example above, who are searching for the unity of existence in nature. They may well tell us that they have feelings of connectedness with the world and things without believing in God or any other holy source. If we regard such feelings as holy experiences, then we again have the problem of defining what is religion and what is not.

I have tried above to show that Pargament's definitions of religion and spirituality, although rich and comprehensive, are problematic in drawing a line of demarcation between a theist and non-theist and that they neglect the spirit of our era. One of the reasons for this, I think, is that the studies on which Pargament and many other researches have based their definitions of religion and spirituality have been conducted in the United States, where the majority of people identify themselves as religious and where, as Pargament (Zinnbauer & Pargament 2005:28) mentions, even those who regard themselves as spiritual admit that they also have a commitment to a religion. As pointed out earlier, the situation is different in other societies, among others those in the Scandinavian countries. Accordingly, in order to define religiosity and spirituality such that they embrace a variety of outlooks on religion and spirituality among different peoples, we need to apply broader cultural approaches. Moreover, we need studies (both qualitative and quantitative) in the field of health, religion and spirituality that focus on the spirit of our era.

Definitions of Religiousness and Spirituality in My Study

Zinnbauer and Pargament (2005) put forward two alternative definitions of religion and spirituality. Both researchers criticize the modern approaches for polarizing religion and spirituality and both believe that definitions of religion as well as spirituality need to be embedded within a context and that the nature of that context can be used to discriminate between the two constructs. Both see the search for the sacred as an important component of religion and spirituality. But while Zinnbauer (Zinnbauer & Pargament 2005:35-36) considers spirituality as the broader construct, Pargament (Zinnbauer & Pargament 2005:36-37) regards religiousness as broader. As we have seen, Pargament (Zinnbauer & Pargament 1999:909) considers that spirituality constitutes a search for the sacred. Religiousness refers to a search for significance in ways related to the sacred. Zinnbauer (Zinnbauer

& Pargament 2005:35) defines spirituality as a personal or group search for the sacred. Religiousness is defined as a personal or group search for the sacred that unfolds within a traditional sacred context.

Despite some problems in Zinbauer and Pargament's definitions of religiosity and spirituality, I consider their general perspective of religiousness, spirituality, the sacred and religious coping to be much more comprehensive and manifold than are other perspectives, and for this reason I use their perspective in constructing my own definitions.

When defining religiousness, in addition to my own definition, I use an earlier definition presented by Pargament and Jenkins (1995:52). Religiousness is defined in my inquiry as:

A search for significance that unfolds within a traditional sacred context (Ahmadi). It is then related to an organized system of belief and practice relating to a sacred source that includes individual and institutional expressions, serves a variety of purposes, and may play potentially helpful and/or harmful roles in people's lives (Pargament & Jenkins 1995:52).

My definition of religion differs from Zinnbauer's in that it regards religiousness not only as a search for the sacred, but also as, in accordance with Pargament's definition, a search for significance. This definition involves a broader goal for the individual and communal search. It then responds to the multifunction that religion has in people's lives. This is because significance involves the sense of satisfaction, value and importance that accompanies the pursuit and attainment of goals as well as the goals people strive for in living. Significance embraces sacred matters too. The latter aspect renders my approach to religion as different from other modern approaches, which neglect the notion that one of the greatest missions of religion is the individual as well as communal search for the sacred.

On the other hand, my definition confines the search for significance to the framework of a traditional sacred context, as does Zinnbauer's definition. This is done in order to reflect the spirit of our time, which takes exception to traditional authority and institutional expressions of belief. My definition, in contrast to Pargament's, enables communication with the general public through its sensitivity to the way people identify themselves in cultural settings in which spirituality is more dominant than religiosity.

Spirituality is more difficult to define. It is obvious that spirituality cannot be put into a box. In order to conduct my study, however, I needed a working definition. I suggest, for this study, a definition that is partly based on my own and partly on Jenkins and Pargament's (1995:52-53) definition of spirituality. Spirituality is defined here as:

A search for connectedness with a sacred source that is related or not related to God or any religious holy sources (Ahmadi). Spirituality involves

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efforts to consider metaphysical or transcendent aspects of everyday life as they relate to forces, transcendent and otherwise. Hence, spirituality encompasses religion as well as many beliefs and practices from outside the normally defined religious sphere (Jenkins & Pargament 1995:52-53).

In this study, the term spirituality refers, thus, to the kind of spirituality that can be experienced without having any faith, without myths, legends and founding super-personalities, without superstition, and that can be practiced in a religious context as well as outside the religious sphere. It is conceivable that, for people socialized in a secular and rationally organized society like Sweden, where people are considered as irreligious, it may hardly be possible to accept as truth many aspects of conventional religions, such as the mythology and legends of super-personalities and superstition. It goes without saying that I am not addressing people with a strong "faith"[2]. The idea is that, because many things are established as theistic, conventional religions are so difficult to accept that, to do so, one must make a supreme effort to overcome rational, logical thought. I have chosen, therefore, a definition of spirituality that focuses on spirituality experienced in a religious context as well as outside the religious sphere. This definition focuses on the higher aspects of human life, and targets individuals who rise above the banality of everyday life and experience a transcendent view of life.

After having clarified the definitions of religiousness and spirituality used in this study, I will, in the next chapter, discuss the views on religion and spirituality found among Scandinavians – particularly among Swedes.

Notes:

[1] For example, one of the informants from the "Atheist group" pointed out that, "So when I've been out in nature, first and foremost, I felt I was myself, that there was time for thoughts, it was peaceful, everything else disappeared. Whatever happens in the world for me or others, nature is still there, it keeps going. That is a feeling of security when everything else is chaos. The leaves fall off, new ones appear, somewhere there is a pulse that keeps going. The silence, it has become so apparent, when you want to get away from all the noise. It is a spiritual feeling if we can use this word without connecting it to God, this is what I feel in nature and it is like a powerful therapy". Here our atheist gives the sacred quality of timelessness to nature when he points out *Whatever happens in the world for me or others, nature is still there, it keeps going.* Through his sanctification of nature as a timeless object, our interviewee, who is not a theist, finds a spiritual feeling.

[2] The word `faith' as used in religion means the ability to believe something despite evidence. The ultimate level of `faith' is the belief in something even though it is utterly obvious to everyone that it is false.

Chapter 4: Religiosity and Spirituality in Sweden

In this chapter, I wish to explain the raison d'être of my research project i.e., to explain why I conducted a study among cancer patients in Sweden regarding their possible use of religious and spiritually oriented coping methods. In this connection, I will focus on the Scandinavian – especially Swedes' – views on religion and spirituality.

Swedes, Religion and Spirituality

There is plenty of research on religious coping methods. Many studies, however, have been conducted in the US where, as has been shown (Pargament 1997; Krause 1997; McAuley et al. 1998), people are involved to a great degree in church activities and where the organizational components of religiousness serve as important health-related measures. For instance, studying how religion and God are incorporated into white elderly Americans' health belief systems, McAuley et al. (1998:9) maintain that white respondents tended to speak about their religious lives primarily in terms of their organizational religiousness (e.g., attending services, being involved in church meals, playing piano at church). As one study shows, nearly 80% of Americans believe in the power of God or prayer to improve the course of illness (Wallis 1996). Maldonado's (2003) study shows that nearly 70% of physicians in the US report patient requests for religious counseling in cases of terminal illness. As King et al. (1994) maintain, 75% of patients in the US believe that their physician should address religious issues as part of their medical care. About 40% of patients want their physician to discuss religious faith with them, and almost 50% of patients want their physician to pray with them.

The situation in the Scandinavian countries, especially in Sweden, is different. The social as well as cultural background of Swedish society is, in many respects, different from that of many other Western countries, especially from the US.

As Halman (1994:59) points out, the Scandinavian countries are generally viewed "as a separate part of Europe, internally homogeneous and very different from the rest of Europe". According to Peabody (1985), the influence

of Protestantism is one of the important factors responsible for the special position of the Scandinavian countries within Europe.

It is perhaps worth mentioning that Christianity did not become the official religion in Sweden until the 11th century. The institution of the Church underwent great changes after the Uppsala Meeting in 1593. A monolithic church was replaced with a monolithic state, which had one of the most complete legislative systems aimed at creating spiritual conformity within a civilized population. This had major consequences for the destiny of Christianity in Sweden. One important historical event in the 18th century was the ordinance of "konventikelplakatet" (Church Laws of 1726). With the growing pietistic movement in the early 18th century, the state church passed a law against the practice of private religious meeting, called konventikel. The law states that only the parish priest may lead religious meetings, except for the head of family who may lead prayers with his family, a practice called husandakt. The punishment for arranging a religious meeting was a fine or even a prison sentence. The high degree of privatization of religion and of secularization of social as well as private life among the Swedes is likely to be due, among other things, to this ordinance. The konventikelplakat was repealed in 1858.

With this law out of the way, several new religious movements were able to prosper. Not all of these groups, however, were accepted by the contemporary society, especially by the church. As a result, many people emigrated as groups, e.g. the "Jansonites" to the Chicago Lake area in the US. In addition to the emigration of many religious people, the labor movement's criticism of the church and Christianity at the beginning of the 20th century may be regarded as one the most important factors explaining the low degree of interest among Swedes in church attendance and religious activities (see Kallenberg et al. 1996). Regarding the religiosity of the Swedish people[1], it is interesting to consider that a large majority of Swedes belong to the national Lutheran Church, but as Halman (1994:63-64) stresses, only a minority in Scandinavian society as well as among church members are committed to the church.

Swedes, Faith and Church

In order to understand why Scandinavians, though not committed to the church, consider themselves members of the Lutheran Church, we should take into consideration that this distinctive pattern may be a consequence of the strong association between the Lutheran Church and the state in Scandinavian countries[2]. According to Halman (1994:64), "Being a church member is almost a citizen's duty in the Scandinavian countries". This can be seen as a way of expressing solidarity with Swedish society and its basic values rather than as commitment to the church as a religious institution (Hamberg 1994:184). Stressing this point, Halman (1994:79) points out that "member-

ship is widespread and is part of Scandinavian identity, but this membership is not accompanied by strong commitment to the church". Such being the case, it is not incorrect to maintain that, in the Scandinavian countries, being a member of the church is probably less religiously meaningful than it is in other countries.

The role of the church in Sweden, as in other Scandinavian countries, is limited. According to the European Value Study 1990 (EVS)[3], Scandinavians

> reject the idea that the church should speak out on personal issues like homo-sexuality, abortion, extramarital affairs, and euthanasia. However, Scandinavians are also less in favour of churches speaking out on various social issues, like unemployment, disarmament, third world problems, racial discrimination, ecology and so on... This may be explained by the fact that more than in other countries the Lutheran church in Scandinavia is an institution merely limited to providing religious services. The church is one among many other specialized institutions with a very limited role in society. As a consequence it is very difficult for the church in Scandinavia to get involved in issues which are ascribed to other institutions… It is therefore not unexpected that Scandinavians are least of all of the opinion that churches provide adequate answers to moral questions, problems of family life, spiritual needs and social problems (Halman 1994: 65).

As it seems, although a majority of Scandinavians belong to the Lutheran Church, their affiliation is not necessarily connected with strong beliefs.

Decreases in religiosity imply a change in the Scandinavian view of the sacred. As the European Value Study 1990 (EVS) indicates, instead of belief in a personal God, people in Scandinavia and Northern Europe tend to believe in some kind of spiritual power or life force. According to EVS, 21% of people in Scandinavian countries believe in a personal God and 40% believe in some kind of spirit or life force. In Southern Europe, the percentage of people who believe in a personal God is 61%, while 24% believe in a spiritual power or life force (Halman 1994:67). In the US, according to the American Religious Identification Survey, in 1990, "ninety percent of the adult population identified with one or another religious group. In 2001, such identification has dropped to eighty-one percent" (Kosmin et al. 2001). According to the General Social Survey in 2000, the proportion of 'nones' – those who say they have no religion – has increased in the US, from 5% in 1973 to 14% in 2000 (Stark et al. 2005:12). According Stark et al. (2005:12), however, such argumentation does not show that people have become less religious, but that they have become less churched religious and more unchurched religious. Stark et al. (2005:12) point out that the General Survey 2000 shows:

> the 'nones' are not the vanguard of secularization, but that most of them pursue privatized religion. Two out of five of these "nones' pray daily or weekly

and only 4% never pray. Atheist are few, the majority believe in God and many of the rest believe in a 'higher power''.

 According to these researchers (Stark et al. 2005:15), "Americans are thought to be among the most religious people on earth".

The EVS shows that in Sweden, like other Scandinavian countries, we are witnessing a replacement of traditional Christian beliefs with less orthodox ones and rather vague beliefs in the existence of a transcendent power, which is not understood as a personal God, as well as beliefs in reincarnation (Hamberg 1994:179). As the result of the EVS indicates

> While, e.g., belief in a personal God has decreased in Sweden during the past decade, a corresponding increase can be seen in the share of the population who believe in a transcendent power other than a personal God: in 1981, 20 percent of the Swedes believed in a personal God and 37 percent affirmed belief in "some kind of spirit or life force"; in 1990, the corresponding shares were 15 and 44 percent, respectively (Hamberg 1994:179).

Regarding the limited role of religion in the life of Swedes, the results of The World Value Survey (WVS) from 1990/1996 (a complementary study to EVS) are striking. One of the aims of the WVS survey was to conduct a worldwide comparison of people's religiosity and philosophy of life. As this survey indicates, Swedes place very low on the ranking with respect to traditional, church-visiting religiosity. Only 15.8% of Swedes believe that God is important in their life. The corresponding figure for Americans is 73% (Petersson 2000:18). As one study shows, 50% of Americans pray every day and 40% attend church on a weekly basis (Mathews et al. 1998:118-124). While almost 58.4% of Americans regard religion to be important in their everyday life, only 9.6% of Swedes see religion in this way (Petersson 2000:18). The differences between Sweden and many other countries with respect to other indications of religiosity are also of significance (Stark et al. 2005). Pettersson (2000:20) stresses that the Swedish people's involvement in church has continually declined during the post-WWII period. According to statistics, monthly participation in the divine service has decreased from 17% in 1956 to 8% in 1998. The same decline in interests in other issues related to religiosity can be also observed in Sweden (ibid.).

Besides the European Value Study in 1990, other nation-wide surveys show widespread belief in a spiritual power rather than a personal God among Swedes. For instance, in 1986, Uppsala University conducted a survey of world-views and value systems among Swedes. This study, called the "Uppsala Study" (Hamberg 1994:179), covered the whole country. The study was based on interview as well as questionnaire data. Like the EVS material, the picture presented by the Uppsala Study shows Sweden as a very secularized country where traditional, church-oriented religion plays a very

minor role in the lives of most Swedes. In this respect, Hamberg (1994:181) stresses that:

> While adherence to the basic tenets of the Christian faith is low, the decline of traditional religion is even more evident in the very low prevalence of such traditional religious practices as prayer, church attendance or Bible reading. While 36 percent of the respondents expressed belief in God or a transcendent power, only 16 percent of the respondents used to pray weekly and only 9 percent attended church at least once a month. In other words, while belief in God or a transcendent power was not very prevalent from a West European point of view, regular prayer and, especially, regular participation in public worship was even less common.

It is noteworthy that the proportion of Bible readers is even less than that of people who pray or participate in public worship (Hamberg 1994:181, footnote 3).

Swedes and Private Religion

Although according to both the Uppsala Study and EVS, Sweden can be regarded as one of the countries in Western Europe in which we are witnessing a decline in traditional and church-oriented religion, other forms of religion have been emerging in Sweden. These forms are usually described using the term "private religion" and assumed to contain such elements as belief in a transcendent power or divinity and/or belief in some form of life after death (Hamberg 1994:184). Certain forms of behavior, such as private prayer or meditation, are sometimes assumed to characterize the "privately religious" (Hamberg 1994:184-185). Wikström (1998:12) describes the change of position of the Church of Sweden and of the way people understand Christian worship during the past decades as follows:

> Privatized world-views compete with the official and societal sanctioned distribution of religious experience. Many new actors are present on the social stage of life philosophies and ideologies. There is a crisis of the legitimization of transcendence. The Church of Sweden is today only one out of many structures maintaining the religious world.

The prevalence of a tendency toward the "privately religious" among Swedes has been confirmed by studies other than the Uppsala Study and EVS. Research conducted among 2003 Swedes in 1993 shows that 33% of Swedes belong to a major group, which can be categorized as "privately spiritual" (Kallenberg et al. 1996:54) (see Table 2)[4].

Table 2. Philosophy of life and church attendance

	Church attendants	Non-attendants	**Total**
There is a personal God	(Church Christians) 111 (6%)	(Privately Christian) 193 (10%)	**349 (16%)**
There is some sort of spiritual or life force	(Ecclesiastically spiritual) 49 (2%)	(Privately spiritual) 647 (33%)	**696 (35%)**
I don't really know what to think	(Agnostics) 13 (1%)	(Agnostics) 548 (28%)	**561 (29%)**
I don't really think there is any sort of spirit, God or life force	0 (0%)	(Atheists) 401 (20%)	**401 (20%)**
Total	**173 (9%)**	**1,789 (91%)**	**n=1,962 (100%)**

If we take into consideration only those with a religious and/or spiritual tendency, as Table 3 indicates, 65% are not used to attending church, i.e., are "privately spiritual".

Table 3. Church attendance among those with a religious or spiritual tendency

	Church attendants	Non-attendants	**Total**
There is a personal God	(Church Christians) 111 (11%)	(Privately Christian) 193 (19%)	304 (30%)
There is some sort of spiritual or life force	(Ecclesiastically spiritual) 49 (5%)	*(Privately spiritual) 647 (65%)*	696 (70%)
Total	160 (16%)	840 (84%)	**n=1000** (100%)

According to Kallenberg et al. (1996:53), in comparison with other European countries, Sweden is placed at the lowest level with regard to "Church Christians" and "Privately Christian". Regarding those who are categorized as "Ecclesiastically spiritual" and "Privately spiritual", Sweden is among the countries at the highest level.

As another investigation (Jeffner 1988) of the concept of life among Swedes shows, the traditional metaphysical ideas about the world as either a materialistic-probabilistic construct or as created and endowed with spirituality are, for most people, not issues at the forefront of their thinking. Many people do consider these issues, but holders of definite views are a minority. This is one of the many ways in which people interpret Christianity in their own way.

One way to explain why Swedes' attitudes toward religion differ from those of many other people in Western countries[5] is to study Swedish peo-

ple's view of the relation between man and God. Because this view is one of the most important factors when applying religion and/or spirituality in coping, I will, in the following, shed some light on the view of man and God among Swedes.

Pettersson (2000:11), when discussing the character and nature of Swedish culture, focuses among other things on the difference between two kinds of religions: "transcendence religions" and "immanence religions"[6].

Regarding the divide between man and God, the "transcendence religions" make a sharp distinction between the two. The "immanence religions", on the other hand, proceeding from a comprehensive picture, advocate the similarity between man and God. Different types of mysticism or religions that persuade man to come into contact with the Real Truth using different unconventional practices (such as meditation) are regarded as "immanence religions". As it seems, the modern Swedish understanding of the relation between man and God is similar to that of the "immanence religions". Pettersson (2000:13) shows this attitude through an example that I find interesting to repeat here: In order to celebrate a new translation of the Old Testament – Bible 2000 – the Swedish Church held in 1999 in the Cathedral of Uppsala an official ceremony. In this ceremony, the Archbishop of Sweden, Karl Gustav Hammar, explained how, in the new translation, an innovative view of the relationship between man and God is presented. In elucidating this new view, he pointed out that in the old translation from 1917, we read that "The Lord lets His face shine over you…", but in the new translation, it states that "The Lord lets His face shine toward you…" The Archbishop explained that the face of the Lord "no longer" shines over us, from above, but toward us, face to face. He explained how we, in a mysterious mirror image, meet God face to face. Here, instead of a hierarchical relation between man and God, we are witnessing an "equal" relation. Pettersson stresses (ibid) that Archbishop K. G. Hammar's statement indicates a clear shift from the "transcendence religions" to the "immanence religions". As Pettersson (ibid.) maintains, the Archbishop is not alone in such a view of the relationship between God and man.

Pettersson (2000:13) refers to a study showing that almost half of the informants who replied that they believed in God chose the response alternative "God is rather something in every individual than someone outside". Twenty-five percent chose the alternative "I believe in a God who I can have a personal relationship with" and 25% chose the alternative "I believe in a non-personal power or force". Accordingly, the majority of Swedes who believe in God are not thinking of a God who exists somewhere out there in another reality. The tendency toward spirituality rather than religiosity is also evident here.

Swedish Culture, Religion and Spirituality

Swedish culture and ways of thinking have played an important role in determining Swedes' views on religion and spirituality in modern times. One of the aims of the WVS (World Value Study) was to compare the fundamental value system of peoples around the world on the basis of their culture and ways of thinking. Pettersson (2000:14-20), who has been greatly involved in this survey, discusses some results of a factor analysis from 1990/1996, which are interesting for our understanding of the impact of culture and ways of thinking in the Swedish belief system. As Pettersson explains (2000:15), two bipolar dimensions are positioned against each other in this survey:

- Traditional rationality vis-à-vis secular-rational rationality: Traditional rationality is characterized by regarding the belief in God and family as very important, viewing obedience as much more important than independence, believing that one should have great respect for authority and hierarchical systems. Secular-rational rationality is characterized by the opposite values.

- The survival value vis-à-vis individual identity and integrity (cultural postmodernization): The survival value is characterized by the belief that economic certainty and security are much more important than individual identity and integrity, that material working conditions are more important than social and developmental psychology, and by a strong belief in science and technology and low social confidence. The other pole of individual identity and integrity is characterized by the opposite values.

This survey shows that the value system of people in the Protestant Northern European countries (including Sweden) is characterized by a high level of secular-rational rationality, on the one hand, and a postmodern view of individual identity and integrity, on the other. Sweden is identified in this study as one of the most secular countries in the world. With respect to individual identity and integrity, some results of this survey show that 55.3% of Swedes become disappointed if they cannot realize their individual life goals. For Americans, the corresponding figure is 31.6%. According to Pettersson (2000:21), the value of individual identity and integrity among Swedes is augmenting, and there is no indication that this augmentation will stop.

The diminishing interest in attending church and participating in divine service and the tendency to disclaim transcendent religion and God as a shepherd, on the one hand, and the augmentation of secularism, on the other, do not mean, however, that the sacred values no longer exist in Sweden. Actually, what we are witnessing in Sweden is conceivably the development of "postmaterialist values", our times' sacred values as Luckmann (1990)

claims – a development that goes hand in hand with individualization. As Pettersson (1994:200) stresses:

> Similarly, the postmaterialist values are by definition related to the need for self-actualization, something often regarded as an individualistic tendency. Furthermore individualism can also be seen as manifesting itself in the gradual transformation and "de-coupling" of traditional and civic values. Thus, the decreasing willingness to legitimate moral convictions by a Christian world view, the increasing emphasis on personal development and achievement in working life, the change from a materialistic value orientation to a postmaterialistic preference in the domain of socio-political domain, can also be seen as signs of growing individualism (Halman & Ester 1991)

Luckmann (1990:238) maintains that the ideas of the individual's independence and personal autonomy are on their way to becoming the sacred values of our time. Seen in this light, the fact that transcendent faith is losing its significance does not therefore mean that the sacred is disappearing. Accordingly, our contemporary emphasis on values such as individual integrity, self-realization and respect for individual freedom offers the individual feature of holiness.

Sweden offers several examples supporting Luckmann's opinion that individual freedom and integrity are the sacred values of our time. One example is the fact that many Swedes, among them even religious people, supported the decision of Uppsala Cathedral Dean, Tuulikki Koivunen Bylund, who had the support of the present Archbishop Karl Gustav Hammar, to allow the controversial photo exhibition "Ecce Homo", a queer version of the life and teachings of Jesus, in the main hall of the Uppsala Cathedral, the seat of the Lutheran Archbishop of Uppsala and Primate of the Church of Sweden[7]. This can be seen as a gesture of respect for individual freedom and integrity.

In celebrating the human being as a supreme value deserving of unconditional love, Hammar (2000:50-52) goes even further and stresses that the important issue with regard to Jesus and his life is that he was a human being, just as we are and that regarding Jesus as the Son of God only has a symbolic signification. In many places in his book, Ecce Homo after 2000 years, Archbishop Hammar proceeds from the idea that our conception of the world during the past two thousand years after Christ has changed drastically and therefore, if we are to understand who Jesus was and who we are, we should take into consideration that biblical stories have a primarily historic meaning: they are to be understood as myths rather than as true in a literal sense (Hammar 2000:22). According to Hammar (2000:22), a symbolic interpretation of biblical stories can return to modern human beings the trust and confidence of which they have been deprived.

The prevalence of such a view of God, Jesus and humankind is not only advocated by the Swedish Archbishop, but finds support, as it seems, among

not so few Swedes. This due to a cultural setting that is based on rationalism, a strong tendency toward spirituality rather than religiosity as well as a profound respect for human individuality and integrity.

In summary:

- In Sweden, church practices and other religious activities have declined drastically during the past decades, perhaps even before the mid-20th century, as some researchers (e.g., Gustavsson 1985) maintain.
- The direction of development of religiousness in Sweden has been toward a subjective, inwardly directed phenomenon with few public attributes (Sundback 1994:139).
- Swedes are more likely to describe their religious lives in spiritual terms. It seems therefore appropriate to talk of the existence of a kind of spirituality rather than religiosity among Swedes.

Concerning these points, we have good reasons to doubt that the assumptions concerning religious and spiritually oriented coping methods presented in current literature on religious coping are valid in a cultural context like the Swedish one, where religion does not play an important role in the life of individuals and where spirituality is more prevalent than religiosity. As this study shows, in addition to the religious coping methods introduced in current literature, there are other methods used by people, like Swedes, who have been socialized in such a cultural context.

We discussed that the change in attitudes toward religion in Sweden during the past decades is an undeniable fact. There are, however, few studies investigating the change in the way people cope with their crises using religion and spirituality when many see the Christian faith as only one among several other ways to relate to the sacred. What we are facing is a considerable lack of cultural approaches to research in the field of religious coping. As Wikström (1998:13) maintains, "the modern Swede must choose his or her spirituality in quite another way than just few decades ago. The church description of the spiritual reality inspired by the Bible is now only one among several different descriptions". Researchers, therefore, need to find more culturally appropriate religious and spiritually oriented coping methods – methods that may be used by Swedes (and other peoples among whom spirituality is more prevalent than religiosity). It is in this respect that we need to develop alternatives to traditional methodological approaches by using a uniquely cultural focus as we explore the experience and expression of spirituality among ailing persons in Sweden. As my study shows, such research can result in the identification of new and unknown religious and spiritually oriented coping methods and styles.

In conclusion, the *raison d'être* of this book is to come a step closer to a cultural approach to the study of religious and spiritually oriented coping. This is motivated in particular by the shortcomings of the literature in this

area, which limit investigation of religious and spiritually oriented coping behaviors in the context of cultures, like the Swedish one, in which people practice their "religion" in a spiritual, subjective, non-organizational way.

Notes:

[1] Here I refer to those who have been socialized within the framework of the Swedish culture and not to minority groups.

[2] In Sweden, the national Lutheran Church, State Church, was until 2000 bounded to the State.

[3] The European Values Study is a large-scale, cross-national, and longitudinal survey research program on basic human values, initiated by the European Value Systems Study Group (EVSSG) in the late 1970s, at that time an informal grouping of academics. Now, it is carried on in the setting of a foundation, using the (abbreviated) name of the group European Values Study (EVS).

[4] Table is based on Kallenberg et al (1996:54). I have added percentage calculations in the Totals column and row.

[5] There are, however, as the EVS shows, similarities in religious belief in the Scandinavian countries.

[6] In distinguishing between these two kinds of religions, Pettersson proceeds from the differentiation made by Woodhead & Heela (2000) between "the religions of difference" and "spirituals of life".

[7] This caused the Vatican to cancel a meeting between the Swedish Archbishop, Karl Gustav Hammar, and the Pope (leading Hammar, in turn, to cancel his visit to Rome) and brought about a groundswell of controversy in the Swedish press.

Chapter 5: Methodology

Data Gathering Method

The design of the present research is qualitative. As qualitative research, this study seeks to understand the phenomena of religious and spiritually oriented coping in a context-specific setting, i.e. Swedish culture. As descriptive and exploratory research, this study – although it discusses, on the social level, the possible influence of certain characteristics of Swedish culture on informants' choice of religious and spiritually oriented coping methods – does not attempt to determine any causal relationship at the individual level. Considering the health circumstances of the participants and the personal nature of the study, I based my inquiry on semi-structured interviews. The reason was that a personal approach would be more sensitive and more likely to reveal true feelings and needs than would use of a questionnaire. Using a qualitative approach had certain advantages. The most important was that it gave me an in-depth understanding of the way participants face their illness and allowed me to see their lives and illness through their eyes.

I began by jotting down questions and themes that particularly interested me. Some caught my attention during an initial literature review, especially in relation to methods listed in RCOPE, while others emerged through considering the Swedish lifestyle and ways of thinking. I then selected a number of themes, and prepared my interview strategy with questions and probes.

The interviews were planned so as to classify informants into different groups according to their answers to questions concerning their outlook on God, religion and their philosophy of life. Answers to the outlook questions were classified into the three groups: the "Atheists Group" consisted of those who did not believe in God or any power that can impact events, the "Theist Group" included those who believed in a personal God and the "Non-theist Group" those who did not believe in a personal God, but in a power that can impact events. None of the informants' answers could be categorized as agnostic.

Because the purpose of the study has been to understand the way informants have dealt with their disease and not to generalize the results in any quantitative way, a purposive sample was chosen. As Reinharz and Rowles (1988:8) maintain:

a purposive sample seeks cases that represent specific types of a given phenomenon. The resulting sample allows the investigator to study the range of types rather than determine their distribution of frequency.

Certain factors are recognized as important in use of religious and spiritually oriented coping methods. Because these factors have been important in the selection of informants, I explain them in the following.

The Impact of Divergent Factors on Religious and Spiritual Coping

It is no doubt that, as Jenkins and Pargament (1995:57) point out, "religious coping may serve different purposes and may be influenced by factors both religious and nonreligious in origin". Base on several studies (Lindenthal et al. 1970; Pargament et al 1998; Spilka & Schmidt 1983; Mickley & Soeken 1993), Jenkins and Pargament (1995:57) discovered several background and situational factors that may have effects on the choice of religious and spiritual methods. Some of these factors, owing to their applicability to qualitative research, are used in the present study:

BACKGROUND FACTORS
Demographics
Functional status
Religious orientation

SITUATIONAL FACTORS
Disease stage
Time of diagnosis
Type/location of cancer

These factors may exert effects on which religious and spiritually oriented coping method is chosen by a cancer patient and on which positive and negative impact the method may have on adjustment. Because my study is qualitative, it is not possible to measure the strength of the correlation between these factors and the chosen method or to examine to what extent these factors relate to the degree of adjustment. Yet it is important to take into consideration some of these factors if we are to better understand the reason for choosing or not choosing certain religious and spiritually oriented coping methods. It should be noted that I have used some of the above-mentioned factors for constructing a guide for strategic selection of the sample.

Background Factors: According to some studies (Mickley & Soeken 1993; Spilka et al. 1985; Vinokur et al. 1989; Levin 1988), there is a relationship between *demographic factors* and religious coping. As it seems, religious

coping is used more often by certain groups, for instance, women more than men, older people more than young adults and adults with low socioeconomic status more than adults with high socioeconomic status (Jenkins & Pargament 1995:59).

Another factor that needs to be considered is *functional status*. Church attendance, for example, may be affected by this factor. Frail elderly or very sick cancer patients – even if they would wish to – are not able to attend church or visit other sacred places.
Religious orientation is another factor of importance that should be taken into consideration. As Jenkins and Pargament (1995:59-60) point out "If one is dealing with an unchurched population, contact with clergy may not be useful, whereas inspirational reading or prayer may be extremely important".

Situational Factors: When studying religious coping among cancer patients, one of the most important situational factors is the *disease stage*. As studies (Lindenthal et al. 1970; Pargament et al. 1998) suggest, religious coping tends to be used under serious conditions.

Based on previous research (Derogatis et al. 1983; Psychological Aspects of Breast Cancer Study Group 1987), Jenkins and Pargament (1995:57) assume that religion may be "more salient to coping when a cancer diagnosis is first made or at relapse (when the threat of cancer is arguably strongest)". Here another factor, namely *time of diagnosis*, is addressed.

Another situational factor, which should likely be taken into consideration, is *type/location of cancer*. Different studies (e.g., Cella & Tross 1986) show that:

> Religious issues also may be important with respect to specific types or sites of malignancy. Cancers that can threat the self-image (e.g., when treatment involves disfiguring surgery) or important areas of personal functioning such as sexuality may have particular existential importance and stimulate the use of religious resources (Jenkins & Pargament 1995:59).

In the following, when explaining the selection procedure, I will present the background and situational factors that have been important in the choice of informants for my study.

The Selection Procedure

Religious and spiritual coping may seem to constitute highly individual projects. Some studies (Mehta 1997; Thomas 1997a; Atchley 1997; McFadden 1995; Coleman 1992) have indicated the importance of the social and cultural aspects of these coping processes. For instance, research on religion

and health has shown that the negative or positive impact of religion on elderly people's well-being as well as the possibility of using religion as a coping mechanism may depend on certain factors: among others, gender, ethnicity and culture, income, educational level and marital status. The qualitative nature of this study does not allow all these variables to be taken into consideration. However, I plan to use a greater variety of variables in a future quantitative study, which will be based on the results of this study. In the present inquiry, the sample was chosen on the basis of *strategic selection* guided by background and situational factors.

BACKGROUND FACTORS
Demographics
Sex: Because a gender perspective is also treated in this study, I planned to include both male and female cancer patients in my study sample.
Age: The informants were chosen among cancer patients 18 years and older. Owing to the rather abstract nature of this study and the need for good recall, I decided to not include individuals believed to be suffering from dementia.

Functional status
One of the religious coping methods is visiting church. Hence, it has been important to examine whether, for instance, the Swedish informants in this study make use of church attendance or congregational attendance. In this regard, the functional status of informants was taken into consideration. This was done because, as mentioned before, physical inability to attend church or participate in religious activities may impact the coping methods one chooses.

Religious orientation
As mentioned before, some religious methods have been regarded as global methods of religious coping. The cultural relevance of these methods, however, has been neglected. One of the aims of this study is to draw attention to cultural aspects by investigating religious and spiritually oriented coping strategies in the Swedish context. Informants were chosen solely among patients who had been socialized in Swedish society and in the framework of Swedish culture, which has been influenced by Protestantism. None of the participants were chosen for their interest in spirituality, religious beliefs or religious practice.

SITUATIONAL FACTORS
Disease stage
As mentioned, in studying the use of religious coping among cancer patients, it is important to take into consideration the *disease stage*. Actually, it is supposed that there is a relation between patients' health situation and their

tendency toward religious and spiritually oriented coping. In the context of this study, then, it was appropriate to include patients with "cancer in an early stage" as well as those suffering from "advanced cancer".

Type/location of cancer
Using religious coping may be important with respect to specific types or sites of disease. This point was taken into consideration when recruiting informants.

Sample

The informants were recruited by contacting The Swedish Cancer Society (Cancer fonden)[1] and several other organizations such as Svenskt Förbund för Ileo-, Colo-, och Urostromiopererade -ILCO- (The Swedish Union for Ileostomy-, Colostomy- and Urostomy-operated Persons), De Blodsjukas Förening i Stockholmsregionen (The Leukemia Patients Organization in Stockholm), Prostatabröderna (The Prostate Brotherhood), Bröstcancerföreningarnas Riksorganisation (Breast Cancer National Organization), and Riksförbundet för blodsjuka (National Association for Blood Disease). These organizations provided lists of persons who were willing to be interviewed. Before preparing their list, several organizations arranged a meeting between me and their members, allowing them to become personally acquainted with my research and me. The individuals on the lists were contacted by telephone, email or post. Some informants were recruited via the Internet. I contacted several cancer organizations with electronic homepages and got permission to write about my research on their homepages and to invite those who wished to be interviewed to contact me. Another recruiting method was to distribute a flyer describing my research at the office of a psychologist who worked with cancer patients. Of course I had the permission of the physiologist in question.

The sample consisted of 51 people (18 men and 33 women) between 25 and 83 years of age. The "age at diagnosis" varied between 25 and 83. The informants were sorted into three groups. It was not my decision to divide them in three groups. The division was made on the basis of the informants' answers to questions concerning their outlook on God, religion and philosophy of life. The three groups were the "Atheists Group" consisting of those who did not believe in God or any Spiritual Being, the "Theist Group" who believed in a personal God and the "Non-theist Group" who did not believe in a personal God, but in a Spiritual Being. None of the informants answered that they did not know what to believe or that they believed that the existence of God is unknown. Thus, I had difficulty in classifying any of them as agnostic. Ten informants were classified as "atheists", fifteen as "theists"

and thirty-two as "non-theists". More detailed information may be found in Table 4.

Table 4. Sample

Sex	Age			Age at diagnosis			Outlook on life		
	18-40	41-64	65+	18-40	41-64	65+	Theists	Non-theists	Atheist
M	0	10	8	2	12	4	6	5	7
W	10	21	2	14	18	1	8	22	3

M: Man; W: woman

As Table 4 shows, the number of recruited women was considerably great than the number of men. The reason is threefold: 1. There are more cancer organizations for women than for men, especially for breast cancer patients. 2. The breast cancer organizations are very developed in comparison with other organizations as regards resources on the Internet, network and volunteer organizations. 3. Women were more inclined to be interested in being interviewed than were men. These factors made contacts with women much easier and more likely to happen than those with men. It was particularly difficult to find young men who were willing to be interviewed. This does not imply, however, that when interviewed men were less open to telling their "illness story" or expressing their feelings about their illness and their suffering than were women. I found no difference in this regard between the male and female informants.

The informants varied regarding the location of their cancer tumor. The different types/locations of cancer among the informants are listed below:

Prostate cancer, Breast cancer, Rectal cancer, Cancer of the large intestine/ Cancer of the colon, Bladder cancer, Neuroendocrine cancer, Leukemia, Uterine cancer.

Interview Process

Interviews were conducted either at the informant's residence or workplace or at a place provided by the cancer organization the informant was a member of. The interviews took between 2 and 3 hours.

The informants were first asked to answer some general background questions, among others questions on their view of God and religion. Based on the answers to these questions, I chose one of the three interview guides, which were prepared for each group. These three interview guides were basically identical. Still, the formulation of some questions, with regard to religiosity and life philosophy, differed in some cases. Although I used an interview guide, my aim was to allow my informants to tell me about their

experiences as they had lived and felt them. Because I realized that telling the story of their disease would not be an easy task, I tried to make the interview resemble a normal conversation. For this reason, I let my informants feel that although I was a researcher who was interested in their illness and the way they have dealt with it, I was also a person who had suffered herself in life and whose approach was subjective rather than objective. I informed them of my life experiences and let them know about some difficult periods in my life. I am sure that including the picture of my own life was a very effective way to make informants feel safe and secure and to make them more open to sharing with me the story of their illness and to answering my questions.

Initially, I was concerned that my being a woman might prevent some male informants, especially those with prostate cancer, from feeling comfortable in telling me about certain problems they have faced because of their illness, but my concern was groundless. There were no problems in this regard. Some informants' openness, especially regarding problems they had faced in their sexual life, was enormous. With regard to the female informants, being a woman helped me establish a connection with them that was sufficiently close. This was an important help both to me, who for the first time was conducting a study among cancer patients, and to the informants, who – although some had experienced being interviewed – for the first time were describing their illness, pain and suffering in a non-medical context.

I must acknowledge that conducting this study has had a profound influence on my view of life. Many times, I left the interview locations with a feeling of hope and joy that the interviewee and I had shared. Yet it also happened that directly after leaving my informant, I sat in my car and cried. I learned from my informants how precious every moment of our life is when we are healthy and not facing a difficult crisis.

I suppose my informants not only influenced me, but were also influenced by this study. Telling the "story" of their illness has presumably brought about a reconstruction of their view of self. It is doubtless the case that coping strategies are related to a very essential layer of an individual's life, thus it was not easy for the informants to bring to the fore the painful process they have gone through. Still, the friendly relationship that was established during the process of interviewing made this effort possible.

Method of Analysis

When the tape-recorded and transcribed interviews were analyzed, certain themes and sub-themes emerged. The first step was coding, thematizing and creating networks of different themes. For this, I have used the Atlas Data Program, which is a visual qualitative data analysis program. Atlas is a workbench for the qualitative analysis of large bodies of textual, graphical,

audio and video data. It offers a variety of tools for accomplishing the tasks associated with any systematic approach to "soft" data – material that cannot be analyzed in meaningful ways using formal, statistical approaches. Here I should mention that, although Atlas can also be used for analyzing the data, I have not used it for this purpose.

The next step was to return to the original interview to make sure that in each interview every theme and sub-theme could be recognized. The inclusion of all relevant information in the thematic condensation was also checked.

The structure of some themes was to some extent related to RCOPE, while the qualitative content was provided by the informants. In addition to themes related to RCOPE, new themes emerged totally independent of RCOPE.

The analysis procedure described above continued until no new themes emerged, thus until additional cases ceased to add new information. The "point of saturation" was reached after 47 interviews; 4 additional interviews were conducted.

After identifying the themes and sub-themes, a comparative study of each interview protocol with respect to each theme began. The last step was to establish the essential characteristics constituting the different religious and spiritually oriented coping methods among the informants.

Validity, Reliability and Generalizability

In qualitative studies, the concepts of validity and reliability are described using a wide range of terms. These concepts are not fixed or universal. As Winter (2000:1) maintains, validity is "rather a contingent construct, inescapably grounded in the processes and intentions of particular research methodologies and projects". Some qualitative researchers (Stenbacka 2001) have claimed that the term validity is not applicable to qualitative research. They have, however, emphasized that there is a need for some kind of qualifying of studies that are based on qualitative data gathering methods.

There is a strong tradition of conducting quantitative studies in the field of medical research. This brings about the expectation that objectivity and, accordingly, validity, reliability and generalizability should be of great concern in all studies, even qualitative ones.

The qualitative method used in this study allowed in-depth exploration of issues surrounding religious and spiritually oriented coping methods in a manner that is difficult to accomplish with a quantitative survey. However, despite pursuit of contradictory perspectives and methods aimed at safeguarding validity, there is always the risk that qualitative analysis remains subjective by its very nature. I have tried to report only consistently identified themes. I noted dissent when present, but there is a possibility that

themes would have been interpreted differently had they come from a different group of respondents.

Care should also be taken in generalizing the findings, as the goal of the study was not to produce findings that are generalizable to all cancer patients in Sweden. My goal was to develop a cultural approach, which would allow us to better understand the religious and spiritually oriented coping methods used by a group of cancer patients. The findings are valuable in that they constitute a model of a cultural approach to studying the barriers to and resources for applying religious and spiritually oriented coping methods in societies where religion is not an integrated part of the social life of individuals and where religion is not easily available in the orienting systems of people. This approach can be used in future qualitative studies in other societies, or as the basis for developing a quantitative questionnaire to be administered across a number of cultural settings or societies (e.g., to determine at a more superficial level the extent to which similar methods are used in different societies).

Ensuring the validity and reliability of qualitative research touches crucially upon the trustworthiness of the study (Seale 1999; Golafshani 2003; Strauss & Corbin 1990). As Seale (1999:266) stresses, the "trustworthiness of a research report lies at the heart of issues conventionally discussed as validity and reliability". In the following, I explain shortly the way I have tried to ensure, to the degree possible, the trustworthiness of my study

- I discussed with other researchers in the Gerontological group at the Department of Sociology, Uppsala University the different stages of the research process and continually informed them about the results emerging from the inquiry. This allowed them to criticize the research manuscript through a developmental process.

- All records were maintained in the form of electronic recordings. These records were developed during rather than after the data gathering session.

- I used a qualitative data program (Atlas) for coding and thematizing data as well as for creating networks of different themes.

- An attempt has been made to include all pertinent information in the final report. This was done to give other researchers the opportunity to develop their own conclusions.

- I did not attempt to keep my own feelings and personal reactions out of the study. This is because I believe that if the qualitative researcher's feelings are relevant to the matter at hand, these feelings should be revealed.

Ethical Considerations

Within the framework of the project, data have been gathered pertaining to the religious and spiritually oriented coping strategies of people belonging to a vulnerable section of the general public, namely those with life threatening

diseases. Because such strategies are related to very fundamental layers of an individual's ego, the act of bringing these issues to the fore is of ethical relevance – in particular because the respondents were sought among people with serious and life-threatening diseases.

In order for endeavors like this to be possible at all, cooperation with potential respondents that is based on trust is a prerequisite. Failure in this regard would result in unacceptable levels of refusals. Here, I made clear to potential respondents that: participation was voluntary; agreement to participate could at any time be revoked without any consequences for the respondent; data would be treated with confidentiality and would not be made available to anyone outside the research team; results from the studies would be published in such a way that identification of individual respondents would be impossible.

Experience shows that the 'sensitive' nature of the subject paradoxically causes people who participate in in-depth interviews to positively value their participation in the study as well as the interview itself. In the very special context of an interview, the respondent is given a chance to talk about and reevaluate personal experiences in front of a person who is sympathetic and – most importantly – who will never interfere in the life of the respondent. I believe some of my informants appreciated their participation. I believe this because, at the end of the interview, some informants told me that they had never talked about their illness in that way and that it meant a great deal to them to be able to speak about their suffering and their struggle with cancer without having to worry about upsetting others. Some mentioned that it was a relief to be able to talk so calmly and with some detachment about what they had gone through.

Nevertheless, utmost care was taken to safeguard the integrity of my respondents and to respect their wishes. Because respondents were recruited with the aid of voluntary organizations for the very people concerned, means of referring those who wished to other platforms for discussion of their situation – outside the framework of research and the present study – were made available to me.

Note:

[1] The Swedish Cancer Society, the most important cancer organization in Sweden, is a non-profit organization whose task is it to collect money and distribute it for cancer research, information about cancer and lend/give support to activities that in different ways contribute to improvements within cancer treatment and care.

Part two:
Findings, Analysis and Final Discussion

Introduction:

Part two includes six chapters: Chapter 6 presents and analyzes findings on some well-known assumptions about religious coping and RCOPE methods. Chapter 7 presents and analyzes findings that touch upon new spiritually oriented coping methods (SCOPE) in the Swedish context. Chapter 8 presents and analyzes findings revealing the "gender-directed" and "age-directed" characteristics of choices of religious and spiritually oriented coping methods. Chapter 9 contains a detailed discussion of the findings and analyses presented in previous chapters. In this chapter, the questions put forward at the beginning of the book will be answered.

Before presenting the results of this study in the following three chapters and discussions of these results, it is important to point out that it was much easier to recognize the religious coping methods the informants used than to recognize the spiritual ones. This is the case for several reasons, among others:

- Spirituality, in our present "postmodern" era, refers to many issues, and therefore the meaning of spirituality has become much more vague than it was before.
- Definitions of religion and religiosity are more established than those of spirituality.
- I proceed partly from RCOPE, and this helped me to recognize more easily certain well-known religious coping methods.

Although I have tried to be as open as possible to an understanding of spirituality that determines what is spiritual and what is not, I have also tried to remain within the framework of the definition presented above. It should not be forgotten, however, that because this work has been done in the qualitative tradition, there is a subjective aspect in the choice of interview excerpts.

Chapter 6: Religious Coping

In this chapter, the findings and analyses that touch upon the following questions will be in focus.

1. Has becoming ill changed the religiousness of cancer patients in this study?
2. Does this study support previous assumptions on religious coping?
3. Which religious approaches do the informants take with regard to responsibility and control in coping?
4. Which kinds of religious and spiritually oriented coping methods used by cancer patients may be categorized as RCOPE methods?
5. In this study, what role has culture played in choosing or not choosing the different RCOPE methods?

In the section *Religion and illness*, the first question concerning one of the essential components of religious coping, i.e. religious renovation, will be addressed. Here I will present findings concerning the impact of illness on changing informants' views on religion. In order to answer the second question, I will briefly introduce results concerning another important component of religious coping, i.e. *Assumptions on religious coping*. In addressing the third question, findings concerning *the Styles of religious and spiritual coping,* the third significant component of religious coping, will be presented. These components have already been presented in detail in Chapter 2. In the second section, which concerns the fourth and fifth questions, I will present findings concerning the RCOPE methods and analyze these findings.

Important Components of Religious Coping

Religious Renovation

Religion may intensify in times of crisis and gain in meaning for some, but it may also lose its significance for others. For some people, a serious illness such as cancer may lead to their becoming more religious, while for others it may lead to doubt. My impression regarding religious renovation is that it can hardly be maintained that any participants in this study became believers as a result of their illness. I found rather a tendency toward rethinking religious and spiritual matters as a result of illness among some informants from

the "Theist Group" and the "Non-theist Group," but not the "Atheists group"[1]. For instance, one of the informants, a 53-year-old woman from the "Theist Group" stated:

> I was very religious for some time, as I was undergoing treatments and so on. But now I feel that this is receding into the background again, somewhat. I still feel I'm a religious person but I do not practice it as before.

What this interviewee tells us is that, during difficult times, she has turned to religion, but when the situation returned to normal, her religious involvement decreased. I find this tendency to be a very understandable and normal behavior. What we are facing here is actually the compelling character of religion. As psychologist Paul Johnson (1959:82) stresses: "In times of crisis religion usually comes to the foreground. The more urgent the need the more men seek for a response". The strength of the compelling character of religion depends on, besides personal factors, the availability of religion, i.e. the extent to which religion is part of an individual's orienting system for relating to the world. As I understand it, religion was already a part of our interviewee's orienting system and therefore religion could compel her strongly during the period of crisis caused by her illness. The tendency toward rethinking religious and spiritual matters is more obvious in what another interviewee, a 60-year-old man from the "Theist Group," stated:

> I have been pondering more upon existential questions than earlier, and then I make a distinction between that and the spiritual as I see it. I used to talk more with others about existential questions, but that depends on two things: first, I am more sensitive to things, and second, the social climate is such. But I have always talked about these matters.

When asked whether her illness has changed her attitude toward religion, one 53-year-old man from the "Non-theist Group" answered:

> No, I don't think it was my disease; instead there have been slow changes. The disease has maybe enhanced certain thoughts about the importance of religion or spiritual values, but that was already coming when the disease struck. So the disease itself has not caused the change.

Another interviewee, a 42-year-old woman from the "Non-theist Group", explained her desire for a reawakening to religion in the following way:

> I left the Swedish Church when I was a teenager; I was very anti back then. But more recently, in recent years especially after cancer, I have started attending church again. I have been to church, sort of, I don't know which way to go. But it has sort of been more present now. I have a kind of desire to believe, you could say. I don't dare believe… I have a kind of struggle there. I cannot say I have become a believer, not at all. But I wish I could believe.

> This is because my illness made me realize that sometimes you need a hand from above and when you do not believe in such a hand you feel lonely.

As I discussed earlier, one of the reasons people "turn to religion" in stressful situations is that religion may be more available to the individual. I also discussed that, according to some studies (Wicks 1990; Kesselring et al. 1986), when religion has never been an important part of the individual's life, there is a great chance that she/he will not change her/his attitude toward religion when faced with critical problems. There are also individuals who do not use religion in times of crises even though religion has always been important to them (ibid.). This is because, besides the position of religion, there are other forces, such as personal and social, which affect whether people involve religion in coping. What is crucial here, I believe, is that, for people with limited means and alternatives, religion may take on great power as one of the resources for coping. But in cultures with greater non-religious resources, and especially if religion plays a more minor role in individuals' everyday lives, religion may be less involved in coping. It has been shown that religion is generally used in coping among weaker social groups. I regard the above-mentioned discussion on the reasons "people turn to religion" in times of crisis as an explanation for why none of the informants has become religious as a result of her/his illness, although some who already were believers began to think more deeply about religion. The Swedish society provides more non-religious resources than religious resources for its citizens. As mentioned before, according to The European Value Surveys of 1990 and other international and national surveys, Sweden is one of the most secularized countries in Western Europe, in the sense that a very low percentage of Swedes adhere to the Christian faith or attend public worship. On the other hand, Sweden is one of the most developed welfare states in the world. In Sweden, weaker social groups receive economic support from the state and therefore their life conditions are much better than those of similar groups in many other countries. Weaker groups hardly need help from charities, such as those run by various religious organizations. My concern is that this, in addition to other factors discussed before, serves to undermine the position of religion in coping in Sweden. So "turning to religion" in coping is not only a matter of culture, but also of the social and economic situation in countries such as Sweden. With changes in these factors, it is possible that the issue of turning to religion will change. For instance, if the welfare state were weakened, we could witness in the future an augmentation of the role of religion in coping.

Assumptions on Religious Coping

As explained earlier, *Event Specificity* is one of the most predominant assumptions concerning the ways in which religious cognitions and practices

are fashioned into patterns of stress-management, physical and mental well-being, personal mastery and internal locus of control, especially in the case of individuals faced with certain life events and difficult conditions. The *Event Specificity* assumption suggests that certain life events are particularly likely to elicit religious coping responses; such events include illness and physical disabilities (Jekins & Pargament 1988; Pargament & Hahn 1986). This study does not show an effect of cancer in eliciting religious and spiritually oriented coping responses among informants.

The other predominant assumption concerning the ways in which religion plays a major role in coping with life events and difficult conditions is *Religious Role Taking*. According to this assumption, individuals may experience a divine personification through identification with various figures portrayed in religious texts (Pollner 1989). None of the informants reported any experience of divine personification.

My interpretation of the result concerning the two above-mentioned assumptions on religious coping, i.e., *Event Specificity* and Religious *Role Taking*, is that both these assumptions require that the individual has developed a strong macro-holy feeling. Concerning *Event Specificity*, as mentioned before, it is partly related to the perception of a "just" world, a world in which good fortune comes to good people and bad people get what they deserve (Ellison 1994:104), a world in which there is a strong societally sanctioned distribution of religious experience, and a transcendent God who judges the individual's behaviors and punishes them. As mentioned, according to Ellison (1994:105), *Religious Role Taking* occurs when the individual, by defining herself/himself in terms of a biblical plight and by considering her/his own personal circumstances from the vantage point of the 'God role,' tries to resolve problematic situations more easily. For this, our individual needs to have internalized the thoughts and experiences of transcendence related to the religious institutions and their narratives, which bring about macro-holy feelings. I hypothesize that, if this study does not support these assumptions, it may be, among other things, because the position of the macro-holy has changed during the past decades in Sweden, as it seems that Swedes show a tendency toward a micro-holy perspective rather than a macro-holy one. We find an explanation in Wikström's (1998) discussion on the change in social forms and the way individuals localize the Holy. According to him (Wikström 1998:12), although the Holy has become increasingly personal, inside religious institutions and their "grand narratives," the macro-holy feeling it is still alive and linked to thoughts and experiences of transcendence. Wikström (ibid.) asserts:

> it is quite obvious that there has been a change of the social forms and localization of the Holy. Micro-holy feelings, the inviolable values and experiences on the private or semi-private level, have no direct connection with the great theological myths or narratives any more.

Expressing a micro-holy feeling rather than a macro-holy feeling, informants in this study showed a greater inclination toward spiritual and personal experiences than toward experiences of Religious Role Taking. We can imagine that, for people who have been socialized in a secular and rationally organized society like Sweden, where people are considered irreligious, it may hardly be possible to accept as truth many aspects of conventional religions – such as the mythology and legends of super-personalities and superstition. It does not need to be pointed out that I am not referring to people with a strong "faith"2. The idea is that because so many things are established as non-theistic, and because conventional religions are so difficult to accept, one must make a supreme effort to overcome rational, logical thought. My study indicates that none of the cancer patients has made such an effort despite the pressures of their illness.

Styles of Religious and Spiritual Coping

As mentioned before, styles of religious coping refers to religious approaches to responsibility and control in coping. Four styles of religious coping are identified: "a '*deferring*' religious problem-solving style in which the individual passively waits for solutions from God" (Kaldestad 1996:9), a '*collaborative*' religious problem-solving style that involves active personal exchange with God (ibid.), '*a self-directed*' religious style in which the individual does not lean on God and finally '*Surrender to God*', which entails an active choice to relinquish one's will to God's rule instead of passively waiting for God to take care of everything (Wong-McDonald & Grouch 2000:149). In the following, I will present a brief summary of the results on these styles.

Concerning the deferring religious problem-solving style, it should be mentioned that, in this study, no use of such a problem-solving style has been identified.

It was observed in one interview, where a 53-year-old man from the "Theist Group" reported using the "surrender to God" style.

Regarding the collaborative religious problem-solving style, some informants, both belonging to the "Theist Group" and the "Non-theist Group", reported that they lean not only on God's power, but also on their own power. They see God as a partner, not as a hand that will pull them out of the difficult situation they experienced, but as a hand to hold in order to get through the situation.

The self-directed religious style can be defined as seeking control directly through one's individual initiative rather than through God's help. Although self-directing is regarded (Pargament 1997:181-182) as one of the religious styles, as mentioned before in Chapter 2, I see no reason to consider a self-directing style as a religious coping strategy. If a person does not lean on God, but instead gains control through her/his own initiative, I have diffi-

culty accepting that such an initiative can be categorized as religious. This is particularly true with regard to people such as Swedes, who are highly secularized. Moreover, there is also evidence indicating that an increasing proportion of Swedes who still adhere to the Christian faith tend to do so with a low degree of personal commitment (Hamberg 1994:183). It is for this reason I use the term "self-directing style" instead of "self-directing religious style" in the following. The self-directed style was the most common style among informants. In all three groups, I found a tendency to rely on their individual initiative rather on God's help when seeking control over the difficult situation they faced.

When presenting the results concerning the RCOPE methods, I will discuss thoroughly the coping methods connected to the four above-mentioned styles.

The Many Methods of Religious Coping: RCOPE

As explained in Chapter 2, based on five key religious functions, i.e., meaning, control, comfort, intimacy and life transformation, a full range of religious coping methods, including potentially helpful and harmful religious expressions, have been identified; these are called RCOPE. As mentioned before, in order to recognize the different religious coping methods used by informants, I added to my interview questions certain items that touched upon RCOPE. This allows me to compare the findings of this study with definitions and items of religious coping based on RCOPE. Chapter 2 contains a list (see Table 1) of the definitions and items of different religiously oriented coping methods based on RCOPE. In making this list, items were chosen that seemed appropriate to this study. In the present interviews, I have found some religious coping methods that can be classified as RCOPE. I have categorized these methods according to the above-mentioned five series of methods of religious coping. In the following, these methods will be presented and analyzed. The items and definitions of each RCOPE method are taken directly from the list of RCOPE methods created by Pargament et al. (2000:522). RCOPE is divided into five groups with respect to each of the five basic religious functions mentioned above. These groups, as mentioned in Chapter 2, are:

- Group 1: Religious Methods of Coping to Find Meaning.
- Group 2: Religious Methods of Coping to Gain Control.
- Group 3: Religious Methods of Coping to Gain Comfort and Closeness to God.
- Group 4: Religious Methods of Coping to Gain Intimacy with Others and Closeness to God.
- Group 5: Religious Methods of Coping to Achieve a Life Transformation.

One of the several methods in the group, Religious Methods of Coping to Find Meaning is *Benevolent Religious Reappraisal*, defined as redefining the stressor through religion as benevolent and potentially beneficial. Using this method, the individual tries to find a lesson from God in the event or see how the situation could be spiritually beneficial. I observed a coping method used by some informants from the "Theist Group" that can be categorized as Benevolent Religious Reappraisal.

One 60-year-old woman mentioned her dialogue with God as a way to benefit spirituality from the situation and to cope with her stressor. She was asked to explain what her dialogue with God was about. She answered as follows:

> Well. It dealt with the meaning of getting ill. What is the sense of Life? What is the sense of having three children if you are going to die of cancer? And will I ever see my grandchildren grow up, now that they've started to arrive… There were many such thoughts. I never got an answer; I was just airing my thoughts. I realized that this illness made me closer to God, it made it possible to have a friendly dialogue with God. This made me feel relaxed. I felt that I could handle the situation, of course not always, but sometimes.

Another interviewee, a 60-year-old man, tried to understand and redefined the situation as follows:

> You end up in a situation, where you form such ideas, small fragments, that you have, maybe, been thinking about for years and then you end up in a situation where the pieces of the jigsaw puzzle start organizing, not falling into their places but arranging themselves. I drew up some of my ideas on paper and so I got to consider the whole thing. The question is: "What is the meaning of Life?" Yes, that the meaning of Life is Life itself. I was talking about this to my supervisor, a personal dialogue with Him. Then I drew up some thoughts and I needed somebody willing to listen to them. ...It's not that I'm a Bible-reader, no. I've read the Bible from cover to cover… I need to find answers to some important questions, which I always wondered about. This makes me feel better, I mean when I talk with God. It is a way to feel mentally alive.

I recognize in the above two citations two different patterns of *Benevolent Religious Reappraisal*. In the first pattern, as in the case of the 60-year-old woman, I see the act of talking with God, the dialog in itself, as a way to feel relaxed and deal with the stressor. In the second pattern, as in the case of the 60-year-old man, as I understand, it is not the act of talking with God, but the contents of the dialog – the thoughts and ideas that this dialog evokes – that are important for redefining the stressor. In the same vein, it is not reading the Bible that is a religious act, but analyzing the religious texts helped him make sense of his situation. I suppose that the interviewee actually used

his illness to obtain answers to the existential questions that his life has posed to him.

A third pattern of *Benevolent Religious Reappraisal* found in this study is to consider the disease as an experience, a spiritual one, that has enriched the individual's life. With respect to this, one 79-year-old man from the "Theist Group" said:

> I had a complicated feeling, a kind of personal cleavage. You might say that you live in many parts and that it can change from gratitude and joy to a state of depression and the things that cause these changes are often very hard to explain. If you are in a difficult position and then receive this kind of message somehow, an experience, then it is strengthening, but then maybe you get a clear sign that "well, that was just a coincidence then", but I still think that the important thing is that you have had an experience that meant something in that situation, and then if you can't give it a rational explanation afterwards, well that's just the way of nature. If there was a rational explanation, then everything about faith and your view of life and so on, would come crashing down, and that's not how life works. I tried to view my illness as an experience that gave me the chance to understand my world and myself better. This helped me to be more rational and to feel better.

Among the four methods concerning the Religious Methods of Coping to Find Meaning, *Benevolent Religious Reappraisal* was the only method reported by some informants from the "Theist Group" as a way to cope with their illness. As it seems, other approaches to Religious Methods of Coping to Find Meaning such as *Punishing God Reappraisal, Demonic Reappraisal* and *Reappraisal of God's Powers* were not used by the informants.

I assume that applying Punishing God Reappraisal, Demonic Reappraisal and Reappraisal of God's Powers as coping methods presumably requires a belief in a God or Devil who can determine the course of individuals' lives: a God who not only created man, but also continually controls man's deeds and his destiny, or in the same vein, a Devil who has the power to change man's life. The prevalent view of God among Protestant Swedes is, however, a God who, although having created man, has left him to determine his own destiny and make his own history. Far from being the only reason, I regard this as one of the possible rationales for why Punishing God Reappraisal, Demonic Reappraisal and Reappraisal of God's Powers, three ways of coping to find meaning, were not found among the informants.

Another group of RCOPE is Religious Methods of Coping to Gain Control. One of the methods in this group is *Collaborative Religious Coping,* which is defined as seeking control through a partnership with God in problem solving.

I recognized a method used by some informants from the "Theist Group" as Collaborative Religious Coping. I categorized understandings of collaboration with God according to two different patterns.

In the first pattern, the patient, God and sometimes the physician all have equal responsibility. Everyone should do her/his best.

One 63-year-old man looks for a partnership with God and his physician for accomplishing the job. He stated this as follows:

> I think we – the doctor, God and I – have a job to do together here, I was determined that I should manage it, but at the same time I reached out for a hand from above. We should all cooperate. And then there were in fact others who have prayed for me.

My understanding is that here the interviewee not only leans on God's power, but also on his own power. Here our interviewee sees himself as responsible for his own life and God as a partner in solving their problem. They work together to tackle the situation. Such a person sees God as a partner, a hand not for pulling him out of the difficult situation he experienced, but a hand to hold to get through the situation.

One 50-year-old woman, who felt unable, as she explained, "to go the whole way alone," sought a partnership with God. She explained this as follows:

> I need some higher power. I am sliding along, in a way, and I try to put confidence in the doctor and I think that "they know what they're doing and I have to trust them." But above all it is God who I hope will show his mercy.

My understanding is that here the interviewee does not passively wait for God to help her. She believes that she has done or is doing her part of the job, but this job was/is not enough, and now she sees the exigency of a new power to change the situation and this power is God's power.

In the second pattern, the patient allocates more responsibility to herself/himself than to God or someone else.

One interviewee, a 40-year-old woman, expressed this idea as follows:

> It is...well, I don't quite know where I get my strength from, if it is some well-founded faith in some vital force. Not God, as in some outsider you pray to and who...If I pray a certain amount my wishes are granted...not like that. You can get strength from God to manage to help yourself...I don't think that God can perform, that God can make some miracle happen specifically for me, and make me completely free from cancer. That I don't think. But maybe he can give me the vital force that, life is wonderful and that it is a gift.

In the same vein, one 67-year-old woman stated that:

> I prayed to him to help me tackle this situation. I did not hand over the responsibility, as he has given me this Life to be responsible for…but in my prayers we are walking side by side and he helps me tackle it.

In this pattern, although God is in the picture as a hand that helps the patient handle the situation, it is the patient who is the main actor, not God. Here, I believe, the tendency toward control and self-direction, a tendency that is strong among Swedes, is quite obvious. Actually, I see this tendency in both patterns described above. I will discuss this issue later.

Pleading for Direct Intercession, defined as seeking control indirectly by pleading to God for a miracle or divine intercession, is another method in this group. Here the person prays for a miracle or bargains with God to make things better. Some informants, both from the "Theist Group" and the "Non-theist Group", reported that they have sought control by praying to God. One 79-year-old man from the "Theist Group," when asked whether he has ever pleaded to God for direct intercession, said:

> When you are in a difficult situation, you almost automatically ask for help and mercy and so on. Then there is the question of an answer to one's prayers, that's a very difficult problem. I think the answer maybe comes in this way, that you get the strength to manage it and then you are freed, maybe not from your ailment, but from the feeling that you can't handle the situation. You gain self-confidence.

One 53-year-old man, from the "Theist Group", answered the same question as follows:

> When I was very down and very sick, I prayed I think, yes I did. Not in the beginning, but later when it got worse. Then I prayed more and more.

One interviewee from the "Non-theist Group", a 25-year-old woman, explained that:

> I did in the beginning. I don't truly believe that there is a God that can help me, but I had a conversation with someone, maybe it was with myself or something or someone who I wanted to hear me. I said: "God if you make me better, then I promise to start doing things I'm not doing now." And I promised to start singing again.

My impression is that the informants were not comfortable admitting that they had begged God to make things better. It seems to me that admitting weakness and needing someone to do things for you, even if this someone is God, goes against their socialization, which promotes independence and self-reliance. Presumably, begging God for help was not part of their religious behavior in normal situations.

As the study indicates, some informants, especially from the "Theist Group", have sought control by praying to God. However, none of the informants stated that they prayed for a miracle, nor was the act of praying a continuing endeavor. As it seems, praying became important when the pa-

tient felt unable to go on or when she/he was facing surgery or a difficult treatment.

Another method, in the group Religious Methods of Coping to Gain Control, which is found in the study is *Self-Directing Religious Coping*. Using this method, the person seeks control directly through individual initiative rather than help from God. I found the self-directed method to be the most prevalent coping method in this study. I have, as mentioned above, difficulty categorizing the endeavors of a person who does not lean on God and who gains control through her/his own initiative as religious coping. In the following, being aware of this difficulty, I present the results concerning the Self-Directing Religious Coping for the "Theist Group" only. (Findings concerning the Self-Directed Coping Method among the "Non-theist Group" and the "Atheists Group" will be presented in the next chapter).

One 40-year-old woman reported that:

> Yes, I believe that it depends on me, because you are so alone anyway. No matter how many people may be supporting you and all that, you have to…and finally there you are all by yourself. And you are very alone in this situation. And if you don't tackle it, nobody else will do it for you. Then, if it is with the help of God? I don't think I've actively thought that God… No, such a God I probably don't have, one that is that active, so I certainly would have to help him out.

Another interviewee, a 36-year-old woman, stated that:

> I'm happy I'm a strong person. Thinking "why me?" That I've never done. Rather, I have thought "why not me?" I've never damned gods, or cursed them, thinking: why should this happen to me? Because there is such a lot of misery in the world, so why should I be left free? Still I like to rationalize rather quickly, find out how I should continue how to tackle this. Come on, I've got to do something about my situation. So somewhere I have a driving force, because I think it's fun to live and I would like to find time for…

Here, both informants point out individuals' loneliness in the face of a life crisis, that, in the end, it is the responsibility of the individual to tackle it. Sitting and waiting for a miracle or begging God or others to change the situation does not go hand to hand with the values and norms of the society they have been socialized in, i.e. a strong individualistic society embedded in the Protestant ethic – using Max Weber's term (1964) – which sees individuals responsible for their own actions.

Actually, in this study, I found informants from all three groups – the "Theist Group", the "Non-theist Group" and the "Atheists Group" – who have chosen to rely on their individual initiative rather than on God's help when seeking control over the difficult situation they faced. My impression is that informants have an inclination to trust their own ability to solve problems more than they trust other sources of power, such as God or a religious

authority. I view this as partly the result of the strong position of individualism in the Swedish culture[3].

Concerning Self-directed Religious Coping, as discussed in Chapter 2, Wong-McDonald and Grouch (2000:150) maintain that "People who are less committed tend to be more self-directive or referring, whereas those who are more committed may choose to work collaboratively with God (Pargament et al. 1998)". In my study, use of the Collaborative coping method was observed both in those who believed in a personal God and in those who did not. As the study shows, fear and powerlessness constitute one of the factors causing some informants to work collaboratively with God in coping and not merely on their own. I found, in this study, that a number of informants from the "Theist Group" as well as the "Non-theist Group" – although they were less committed Christians or non-committed Christians – sought more active collaboration with God or a power for solving their problems because they felt powerless or were frightened. One interviewee, a 57-year-old woman from the "Theist Group," says in this respect:

> Someone with higher power should manage this, I can't. I'm frightened. I feel that I'm powerless. I try to believe in physicians, in myself and in God. I can't handle it alone, not any more. I do my best, but I need this power to help me.

I think the question of who turns to God and who relies on herself/himself in a critical situation is too complicated to be answered by solely referring to the extent to which individuals are committed. One of the most important factors in this regard, besides background and situational factors, is the culture within which the individuals are socialized. The role of culture in coping has already been discussed in Chapter 2; here, it is perhaps enough to stress that culture influences the ways in which people cope with crises and consequently impacts on whether or not people turn to religion and whether, as believers, individuals choose to get help from God or to face the crisis alone.

Religious Methods of Coping to Gain Comfort and Closeness to God is another group in RCOPE. *Seeking Spiritual Support* is one of the methods in this group, where searching for comfort and reassurance through God's love and care is in focus.

Some informants from the "Non-theist Group" as well as the "Theist Group" stressed that they have sought spiritual support. One interviewee from the "Non-theist Group", a 47-year-old woman, pointed out that:

> Then I began to think more and more about spirituality in relation to my situation. Even if you don't believe in God, in such a situation you begin to ponder: "What if there is a God". You pray to God and seek his love almost for security reasons. Even though when I was very sick I had difficulty saying "God help me", I did have such thoughts. I was too weak to go through that miserable situation alone.

One 57-year-old woman from the "Theist Group" stressed that:

> The spiritual issue was always there. But when you face a crisis you need help. In such a situation I think many become religious even if they don't use this term. You feel that you can't control the situation any more, and then you begin to become more receptive and show more humility. Your thoughts become deeper, you begin to think about life and death and the meaning of your life. I wasn't sure if I could handle this illness, I needed help. I needed His love.

My understanding of the above citations is that both informants are telling us about the augmentation of their tendency toward seeking God's love and searching for support from Him when they were facing a crisis brought about by cancer and found themselves unable to control the situation. I assume that not only the individual's outlook on or philosophy of life, but also her/his confidence in her/his ability to handle the situation plays a role in this regard. In other words, in some cases, when the patient cannot trust her/his own ability to handle the situation, she/he feels a need for help from different sacred sources, even though there may be no belief in God or in God's ability to make miracles happen. Such a person may seek God's help, as one interviewee stressed, "for security reasons".

Another method in this group is Religious Focus. Here the person engaging in religious activities, such as praying, thinking of spiritual matters or going to church, is trying to shift focus away from the stressor.

A number of the informants from the "Theist Group" confirmed that they have used religion to avoid thinking of their disease. One 53-year-old man said in this connection that:

> I am trying to avoid thinking of my disease by thinking about spiritual things. The Holy Communion is such a thing.

One 40-year-old woman stressed that "It happened that I thought about the life of Jesus".

None of the informants, however, reported engaging in any special religious activity or praying or visiting church in order to shift her/his focus away from the stressor. My understanding is that the method all these informants used was that of thinking about spiritual matters.

Another method in the coping group Religious Methods of Coping to Gain Comfort and Closeness to God is *Spiritual Connection*. This method is defined as an experience of a sense of connectedness with forces that transcend the individual. Here the person looks for a stronger connection with God or seeks a stronger spiritual connection with other people. Some informants, all from the "Theist Group", stated that they have used this method.

I found three patterns of spiritual connection in this study. In the first pattern, the experience of connection is based on the patient's religious belief in

Reunion. Related to this, one 83-year-old man explained his search for spiritual connection as follows:

> Religion has not only played an important role in dealing with my illness, but it has been the determining factor. The keyword is *Reunion* with God, with Jesus. As we can read in The Gospel according to St. John Chapter 14:27 – 28, "I go away, and come again unto you. If ye loved me, ye would rejoice". I am waiting to join Him, wherever He is. This reunion has already begun; I have begun to feel it.

As I understand the above citation, the interviewee's faith has helped him to overcome the fear and anxiety his disease usually brings about. I believe the promise of reaching a unity with the beloved (*Reunion*) has helped him deal with his disease. He emphasizes several times during the interview that, after the death of his wife, he felt he was ready to leave this world and for this he had waited a long time. So regarding the point that he believes in a life after death and his enthusiasm for *Reunion*, I believe he has used religion in coping to a high degree.

The second pattern represents a spontaneous feeling of spiritual connection, which suddenly fills the individual without regard to any religious assumption or faith as such. One 43-year-old woman's experience indicates this pattern. She explained this as follows:

> Last Sunday I was walking in the forest near my house. It began to rain. I suddenly felt that I was the raindrops, I was the forest, and I was the flowers under my feet. I was the universe! It was an unbelievable feeling, short, but strong, I felt I was He. Such experiences have become more and more frequent after I got sick. I feel a sort of belonging or being connected to a bigger unity. This has been my rescue, in the terrible situations I sometimes face.

Here the interviewee did not express, as did the 83-year-old man in the previous citation, an expected spiritual connection due to religious conviction. What she experienced was, I assume, a sudden event, which caused her not only to discover a feeling of spiritual connection, but which became a way to cope with her disease.

In the third pattern, a philosophical view of the world is the basis of the experience of spiritual connection. One 40-year-woman stated that:

> I believe that everything in our universe is connected. I don't believe that my illness is an accidental occurrence. I'm more fantastic than being only a clump of amino acids. I feel that I'm connected to everything and simultaneously to something bigger than all of us. I have begun to think and to feel this more and more now.

My understanding is that this interviewee's experience of spiritual connection is neither due to a theological understanding of the *Reunion* nor to a

sudden event. Rather her way of seeing the world and her philosophical understanding of the universe paved the way for a feeling of union with a greater unity. This caused her not only to discover a feeling of spiritual connection, but also to see herself and her disease in another light, in the light of a unity of existence. This, in its turn, I believe, has helped her to cope with her disease.

I consider that these three patterns represent three different attitudes toward spiritual connection, yet they all present a coping method that helps the patient connect herself/himself to an immense unity, thereby avoiding the feeling of being left alone to suffer.

Another method in this group is *Spiritual Discontent*. In this method, expressing confusion and dissatisfaction with God's relationship to the individual in the stressful situation is in focus. Here we see a religious reframing of the sacred as one of the ways in which individuals deal with a traumatic event. Spiritual Discontent is, according to Pargament (1997:290), one of the harmful forms of religious coping. On the other hand, we should take into consideration that, as Pargament (1997:291) stresses, "perhaps expressions of religious anger should be understood as a "positive disintegration" (cf., Dabrowski 1964) an initial, cathartic, yet painful step in the process of constructive change".

Some of the informants from the "Theist Group" reported having felt that God has abandoned them and becoming angry with Him. One 47-year-old woman, when asked whether she has ever felt confused or dissatisfied with God, answered as follows:

> Yes, I've had thoughts like "why do you expose me to this, why do I have to go through this?" And certainly on several occasions I've asked, "do you really exist, when you permit things like this?" I felt very alone. Even God has abandoned me.

One 79-year-old man stressed that:

> There were clearly some occasions when I questioned God, maybe not His existence but in a way His mercy and ability to do something. Sometimes when you are totally collapsing and wishing it would come to an end even if the price is your life, then you ask why He doesn't at least show His grace and help you escape the misery by taking your life. Yes it has happened that I was angry with Him and had difficulty believing in God's power or mercy. This made me deeply depressed.

These citations illustrate the two patterns I found concerning Spiritual Discontent. My interpretation is that although both informants state their dissatisfaction with God, they point out different reasons. In the first case, the patient is angry because she was stricken with illness. She calls into question the existence of God. The problem the patient faces here is the Theodicy

Problem. The patient wonders why God, who is supposed to love his children, has exposed her to such a terrible illness. In some cases, this "why me" question can lead to seeing the sickness as God's will and therefore to passively accepting it. Or the patient may, as in the story of Job, regard her/his illness as "Educational Theodicy" (Dein 1997). Our interviewee, a 47-year-old woman, did not yet regard her sickness as God's will, but she began to have doubts about God' existence. She was angry and felt helpless and alone. Here religion does not benefit the patient. It has presumably played a harmful role in coping by strengthening her feeling of being alone and abandoned.

In the second case, the interviewee, a 79-year-old man, does not call into question the existence of God, but he questions God's ability to make any difference in his situation. The problem here is not the Theodicy Problem. The interviewee does not feel he has been abandoned. If God does not do anything for him, it is because His power is limited. Here we are facing a way of reframing the sacred by questioning God's omnipotence and absolving the sacred of any responsibility for life's events. In this case, religion, though not harmful, was useless in helping the interviewee maintain a sense of control in the face of the stresses and strains caused by the illness. At any rate, in neither case has religion played a positive role.

Briefly, concerning Religious Methods of Coping to Gain Comfort and Closeness to God, thinking of spiritual matters, developing a sense of spirituality and seeking spiritual support seem to be more prevalent among informants than is engaging in religious activities or performing any religious ritual. I could not find, in this study, any interviewee who reported that she/he had sought religious comfort through religious activities such as attending church service, visiting church, praying, reading the Bible or engaging in charity activities.

As I discussed in Chapter 4, belief in a personal God has decreased in Sweden during the past decades, whereas belief in a transcendent power has increased (Pettersson & Riis 1994). Thus, although a large majority in Sweden belongs to the Lutheran church, the proportion of people committed to the church form a minority in Scandinavia as well as among church members (Riis 1992:1). Hence, in Sweden, the prevalence of the coping methods thinking of spiritual matters, developing a sense of spirituality and seeking spiritual support is presumably not based on belief in traditional religiosity, but rather on what we called "post-materialistic spirituality". That we could not find informants who visited church, prayed or read the Bible in order to obtain religious comfort in a time of crisis is not unexpected and is in accordance with findings of other studies. For instance, according to a nationwide study among Swedes, only 16 percent of respondents prayed weekly and only 9 percent attended church at least once a month (Hamberg 1994:181). According to another nationwide survey carried out in 1984-1985, only 5

percent of the population read the Bible every week, while another 3 percent read the Bible monthly (Pettersson 1986).

None of the methods in the group Religious Methods of Coping to Gain Intimacy with Others and Closeness to God was used by informants. What is crucial in all three methods belonging to this group, i.e., *Seeking Support from Clergy or Members, Religious Helping, Interpersonal Religious Discontent* is the relation with **others**. In the first method, searching for comfort takes place with the help of other people, i.e., congregation members and clergy. In the second method, gaining comfort by praying or giving strength to other persons is in focus. In the third method, dissatisfaction with others, the clergy is emphasized. Because my study is qualitative, it is difficult to establish the reason for the absence of any of the methods belonging to the group Religious Methods of Coping to Gain Intimacy with Others and Closeness to God among the informants. I can still hypothesize, however, that one reason may be Swedes' tendency toward self-reliance and disengaging other people when faced with a difficult situation.

As the study shows, none of the three methods, i.e. *Seeking Religious Direction, Religious Conversion and Religious Forgiving,* in the group Religious Methods of Coping to Achieve Life Transformation were found among the informants. Although some informants reported that becoming ill has had an impact on their outlook on life and caused a life transformation, no one has indicated the role of religion in this respect. I had difficulty drawing any concrete conclusions concerning Religious Methods of Coping to Achieve Life Transformation, but I hypothesize that the strong position of secularism and rationalism in Swedes' ways of thinking has probably prevented religion from playing an important role in bringing about a life transformation that could result in a complete change in their present way of life and lead them to a new path, God's path.

In the above, I have discussed findings concerning the divergent RCOPE methods. Before finishing this chapter, it should be mentioned that this study has identified a RCOPE method not found on the RCOPE list. I call this method *Sanctification of Nature*. In my view, this method can be categorized as a religious coping method belonging to the group Religious Methods of Coping to Gain Comfort and Closeness to God. This method is presented below:

I found that some informants used nature as an important religious coping method to gain tranquility. In this regard, one 53-year-old man from the "Theist Group," when asked whether he prayed or visited the church when he was ill, answered:

> No...No...I walked in the woods. I'm a nature-lover. Experiencing nature has a lot to do with my Christian faith. As a natural scientist I see proof of Gods existence. I think about nature and then creation. In the botanical system you see exciting patterns that strengthen your faith in God. This was much more

important to me than anything else in dealing with the strains caused by cancer.

Another man, 53 years old and again from the "Theist Group," explained how he views nature as a remedy for his cancer-related problems.

> That is where I see the divine force, in nature. I don't see nature as something one simply observes, something beautiful, aesthetic as such, but nature is a proof that there exists a divine force; this is how this divine force expresses itself in nature. Although I have always felt this way, it was enhanced during the sickness. But sometimes, I could feel a sort of grief that nature was so beautiful and there I was out in it although I was so sick. I get strength from nature. It has been a great help to me in finding myself. It has given me the tranquility I need, I had lost myself, my tranquility the day my doctor informed me that I had cancer.

In Chapter 2, it is mentioned that people sanctify different aspects of life in their search for significance. In the above examples, I suppose the informants perceive a sacred value in nature that includes the attributes of transcendence, of the holy. As I understand, the informants cited above see clearly the manifestation of the divine in nature.

Finding tranquility or gaining strength from nature as such does not render experiencing nature a religious coping method. I believe that what makes nature a religious coping method is that such environments become sacred objects or sacred places much like a church. The sanctification of nature will be discussed later on. The coping method *Spiritual Sanctification of Nature*, which is not found on the RCOPE list, will receive more attention in a broader perspective, a spiritual one, in the next chapter, when I discuss the new spiritually oriented coping Methods found in this study. We will see how people search for connection or significance *in nature*, *through nature* and *with nature*. In the next chapter, I will present and analyze my findings on the new spiritually oriented coping methods observed in the Swedish context.

Notes:

[1] For definition of these three groups see Chapter 5, section 3.

[2] The word `faith' as used in religions means the ability to believe something despite evidence to the contrary. The ultimate level of `faith' is the belief in something even though it is utterly obvious to everyone that it is false.

[3] The high number of people who are members of trade unions should not been seen as an indication that Swedes are collectivists and that the Swedish culture is group-oriented. The strong position of trade unions in Sweden is actually related to the Swedes' strong inclination toward organization and a result of the cooperative arrangement of the society, which is completely different from collectivism.

Chapter 7: Spiritually Oriented Coping in the Swedish Context

In this chapter, the following questions will be discussed:

1. Which spiritually oriented coping methods, in addition to the methods listed in RCOPE, have informants used?
2. What has the role of culture been in the choice of these "new" spiritually oriented coping methods?

To answer these questions, I will focus on the methods – used by the cancer patients in this study – which cannot reasonably be seen as RCOPE, but rather can be categorized as spiritually oriented methods.

I present and discuss these methods in two sections: In the first section, methods in some way similar to some of the RCOPE methods will be taken into consideration. These are called SRCOPE and consist of Punishment, Benevolent Spiritual Reappraisal, Collaborative Spiritual Coping, Spiritual Discontent, Spiritual Prayer, Self-Directing Coping and Spiritual Support.

In the second section, the spiritual methods not related to the RCOPE methods will be discussed. These are Spiritual Connection with Oneself, Spiritual Sanctification of Nature, Positive Solitude, Empathy/Altruism, Search for Meaning and Visualization, Healing Therapy, Spiritual Music and Meditation.

Section One:
New Spiritually Oriented Coping Methods
Similar to RCOPE

Punishment

As mentioned in Chapter 6, none of the informants reported that she/he has redefined the stressor as a punishment from God for her/his sins. Some informants admitted, however, that although they did not believe in God, or regard their illness as God's punishment, they still considered their illness as a kind of penalty, though not a religious one. I call this method SRCOPE-*Punishment*. I found two patterns here. Some informants believed that a punishment from an unknown or unexplainable power had caused their cancer and that this punishment was for their "bad" deeds, but not their sins. Others thought that their illness was their body's punishment for their unhealthy lifestyles. Regarding the first category, one interviewee, a 43-year-old woman from the "Non-theist Group," explained that:

> I believe that if you have some sort of basic foundation of faith then it becomes a bit easier, but it isn't decisive. For me it feels good considering my belief in cause and effect. "All that is given will be received", the charismatic lesson. I'm sure my poor relationship with my mother has to do with my breast cancer. Mother apparently translates into breast in Latin.

Here our interviewee copes with her illness by accepting it as a result of her bad deed, i.e., her poor relationship with her mother (negative coping). Being stricken with cancer is regarded here as a penalty, or a lesson.

In the same vein, another interviewee, a 35-year-old man from the same group, said:

> Once I thought what harm have I done in this world that I'm being punished in this way. I believe there is a power that causes our bad deeds to come back to us like a ball comes back when we throw it at a wall.

My impression is that the interviewee, by reframing his illness as well-deserved punishment, has sought to gain a sense of control over the situation and that this helps him cope with his illness.

Regarding the second pattern, one 57-year-old woman from the "Theist Group" affirmed that she did not regard her illness as God's punishment for her sins, rather as a reaction of her body, its revenge on her for her way of life. She explained this as follows:

I've been touching it and thinking like: "what …what evil have I done? What wrong did I do?" I believe, well, than I'm getting into those bits of biological, we take in a lot of substances that are no good… But if you're running at such a high rate year after year, stressing on as I did, then your body cannot cope with it. Then I believe the body reacts intensely. And in my case I think I had an inclination toward just cancer of the breast. So I've been reckoning. For twenty years I've been stressing like a madman. We are a part of Nature, but we damage it and ourselves too. It's not surprising then that Nature gets revenge on us in her own way. We should pay back, shouldn't we?

The answer of one 36-year-old woman from the "Non-theist Group" to the question of whether she has ever considered her illness a sort of punishment shows the same conviction:

I always was in such a rush in my life, have been running, and have been asking: what is my mission in life? I've almost been angry. This should be stopped. My body didn't want it. It punished me. Nature has its own logic. I do not believe in soul in the meaning that there is a life after death, but I believe that our body is more than a biological machine; it has its own power, this is the mystery of life.

In analyzing these citations, I proceed from Pargament's discussion on reframing the sacred. In reframing the negative events, as Pargament (1997:222-232) maintains, sometimes people reframe the sacred. In doing this, individuals use different methods. Some of these methods, such as Punishing God Reappraisal, Demonic Reappraisal and Reappraisal of God's Power, have been discussed above. When we confront a difficult event, reframing the sacred may change the way we think about ourselves or the event in question. In other words, the focus of reframing may be on the person or the event (or a combination of both). In both patterns outlined above, the focus is on the event, i.e. the individual's bad deeds or lifestyle.

One point that should be remembered is that there is a difference between regarding illness as *a natural result of our bad deeds or unhealthy lifestyle* and regarding it as *a result of the punishment of a power* – whatever it may be – for committing bad deeds or for having an unhealthy lifestyle. In the first view, the point of departure is a materialistic outlook that sees illness as a logical consequence of unhealthy lifestyles. In the second view, it is not our deeds that cause the disease, but the act of a power that wishes to punish us. Here, there is something mysterious in the picture, something that touches upon the spiritual dimension. The informants cited above did not see their illness as a natural result of their deeds or lifestyles, but as a punishment of a power, an unknown and inexplicable power or their own body. As they explained, they are convinced about the effect of this power on their health, but they have difficulty convincing others. Thus, what we are facing here is not a simple materialistic explanation of the cause of their illness, but something that is, according to them, mysterious or spiritual.

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Another point that should be kept in mind is that, viewing coping from a functional point of view, the reframing of negative events may endanger the individual's psychological or physical well-being, or may result in the reconstruction of a new view of life in a new perspective. One example of the latter is reflected in the following citation from a 36-year-old woman from the "Non-theist Group":

> I think I should accept my situation and don't think negatively. I can't give up, I'm a fighter and believe in the positive outcomes of events, even the most negative ones. I think I've changed as a person after this illness and my view of myself and life has changed. I live day by day now and enjoy it. I appreciate the small things. It's wonderful.

In my study, I found that informants' reframing of the negative events generally led to a positive outcome rather than a negative one. One of the factors determining whether the outcome of reframing is negative or positive is the culture within which the person is socialized. In my opinion, two characteristics of Swedish culture may contribute to the positive outcome of reframing. One is pragmatism. Some researchers (Pettersson & Riis 1994) consider pragmatism to be one of the most important components of Swedish ways of thinking. The other involves long-term planning – the exaggerated belief that every aspect of life can be planned, which in turn brings about a kind of optimism regarding individuals' ability to determine the course of their own life. Concerning optimism, it is regarded as the national religion of Swedes (Battail 2004:4). One reason is perhaps the effects of the long-lasting predomination of social democratic ideas in Sweden. As a result, an achieved utopia resides in a sort of optimist evolutionism, in the conviction that man can shape his own destiny and that nothing is predetermined (Battail 2004:4).

Benevolent Spiritual Reappraisal

In Chapter 6, it is pointed out that one method used by some informants from the "Theist Group" may be categorized as one of the RCOPE methods, Benevolent Religious Reappraisal. This method is defined as redefining the stressor through religion as benevolent and potentially beneficial. Some informants, who did not believe in God and reported that they did not receive any benefit from religion, admitted that they have tried to see how their situation could be spiritually beneficial or to find a lesson. Here, this is called SRCOPE- *Benevolent spiritual reappraisal.*

I found two patterns in this respect. The first pattern is that informants reinterpret the situation, such that it could be spiritually beneficial. The second pattern is that informants try to learn a lesson from the situation. Regarding

the first pattern, one 36-year-old woman from the "Non-theist Group" described how she saw a kind of spiritual benefit in her becoming ill:

> In a way it became a legitimate reason, this sickness to develop that part, I mean spiritual dimension, and that I find extremely exciting, or important, to understand what the spiritual laws of life are and so on. Because I don't think the world is just. And I don't think people are kind to one another. But it has to... For me to keep on living, then I have to believe that there is something good and something to work toward, and strive for, if life is to be meaningful. And I don't think I've quite found my way there, but I want to get there... And I still haven't done so, so I must go on living for a little while longer.

It is not so surprising that facing life's dark side can cause the individual to question the meaning of life and to try to understand the purpose of life and death. My understanding is that the interviewee redefines the situation by giving it a spiritual meaning. Thus, through her illness, she tries to reach a spiritual way of interpreting life. This endeavor itself helps her cope with her illness.

Concerning the second pattern, i.e., learning a lesson from the situation, the answer of one 25-year-old woman from the "Non-theist Group" to the question "Have you ever thought: Why me in particular?" shows this pattern:

> No, I don't think one should keep thinking like that, I mean why me... Because well, this thing was apparently meant to happen. One should try, or I thought, yes, if I survive this, then it's like a good experience that could come in handy. But then I thought that if I were to become too sick and die from this, I would not understand the meaning of it. And since I believe that everything has a meaning to it, well I believe, believed that things would get better, sort of. So this makes me feel a kind of spiritual joyfulness.

I get the impression from the above citation that because she believes that everything has a meaning, the interviewee wants to gain a life experience from her situation and to understand the meaning of life. The idea that in the end everything will get better, because it is a result of a meaningful process in life, gives her a spiritual feeling, which becomes her coping strategy.

I think one factor that may have caused informants to try to gain a spiritual benefit from their illness is the strong tendency in Swedish culture toward spirituality, on the one hand, and plan-oriented optimism, on the other. As we discussed before, Swedes are more likely to describe their "sacred" feelings and lives in spiritual terms than in religious ones, and it seems there exists a rather strong tendency toward spirituality among Swedes. On the other hand, it is pointed out that Swedes are generally regarded as optimists and pragmatists. Given these cultural characteristics, it is not difficult to understand why informants who stressed that they were neither religious nor had faith in God have tried to benefit spiritually from the situation of facing cancer.

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Collaborative Spiritual Coping

It has been shown in the previous chapter that some informants sought control in problem solving through a partnership with God. Other informants, among both the "Theist Group" and "Non-theist Group", sought a partnership with a kind of non-God power – sometimes without being able to explain exactly the nature of this power. This search is called SRCOPE-*Collaborative Spiritual Coping*. I recognized two patterns. In the first pattern, the interviewee has sought partnership with a kind of Spiritual Being. In the second pattern, the interviewee believes in collaboration between the individual and destiny.

Regarding the first pattern, one 53-year-old woman, from the "Theist Group", explained that:

> I don't think I thought that like God does what he can to make me healthy. But in some way I felt there was this strengthening force. I learned to sing this song when I was little: "I don't walk alone here, alone here..." And that song, I know this, was grinding in my head. I am not alone in this. There is some force that helps me. And that repeated itself during this time.

Another interviewee from the "Theist Group", a 50-year-old woman, unable, as she explained, "to go the whole way alone," sought a partnership with a higher power. She stressed this as follows:

> I need some higher power. I am sliding along, in a way, and I try to put my confidence in the doctor and I think they know what they're doing and I should trust them. But I need more support, not God, no I have not thought in this way, but something that surrounds us, maybe something inside me, I don't know how to explain it.

One 42-year-old woman from the "Non-theist Group," when asked whether she thought she should herself take charge of her situation or needed other support, answered:

> One could say a form of co-operation. That I must take care of myself in a good way, so I can have faith in a positive outcome. Then there is someone that helps, if I can put it that way. If I do my part, it will do its, not God but something, some Being. It is difficult to describe my view; there is something that is on my side. But if I continue to be destructive, live in a destructive way, the disease will come back somehow.

The first pattern, in my opinion, shows the informants' wish to not be left alone in their difficult situation and their need for some power, a spiritual one, to lean on, to be a partner in their difficult journey. Here I see the informants' search for control through a partnership with some spiritual power as a method of coping with their illness.

The following dialog with one 40-year-old woman from the "Theist Group" illustrates the second pattern, i.e. collaboration between the individual and destiny:

> I: Was it that, you thought that, now I've done my best, and now God is in charge or has control?
>
> Interviewee: Yes, in some way, destiny, yes.
>
> I: Destiny or God?
>
> Interviewee: They are the same. I don't believe in a God that distributes evil or good. I feel in a way that my story is my story. My life will be what it will be. I don't think that some God sits up on high and distributes things to us. I do my best but destiny is there, it does what it should do. We collaborate to realize my history.

One 34-year-old woman from the "Non-theist Group" explained the role of destiny as follows:

> I think that I have done my best, but maybe there is something else now that is in charge. Maybe one could sum it up that way... I have done may part and now destiny can do the rest. My destiny and I deal with my disease as two friends. This doesn't mean that I let it be, no, I'm fighting in my way and get strength from the idea that my destiny is there facing my cancer in its way. Some friends find my idea about the role of destiny crazy, but it helps me to feel tranquil. I'm not worried any more.

Here also we see the reframing of negative events using a positive outcome. The informants accept their illness as a part of their life circle, their destiny, without giving up or being passive for that reason. The first interviewee stresses that "I do my best but destiny is there". And the second one points out that "I think I have done my best". Thus, by regarding their illness as part of their destiny, they try to establish a kind of collaboration between themselves and their destiny "to realize their history", to achieve a result that is the best or most likely.

In both patterns the informants used a coping style that involved getting encouragement and strength from a "power" instead of waiting for a miracle from God to make things better. As we can see, not only among the "Non-theist Group" but also among the "Theist Group" there was an inclination to seek control by obtaining power from a spiritual power other than God in order to deal with the stressors caused by illness. Here I see the footprint of a tendency among Swedes toward describing their sacred experiences and feelings in spiritual terms rather than religious terms. Some studies (Kallenberg et al. 1996; Jeffner 1988) have witnessed this tendency.

It should be mentioned that informants from the "Atheists Group" have not shown any tendency toward getting help from any otherworldly power. Some mentioned that they only rely on themselves; some, besides their own efforts, rely on Science.

Spiritual Discontent

Spiritual discontent may be seen as an expression of confusion and dissatisfaction with God's relationship to the individual in the stressful situation. SRCOPE-*Spiritual Discontent* refers, on the other hand, to an expression of confusion with the existence of or the relationship to a Spiritual Being/beings among those individuals who do not believe in God. One interviewee, a 46-year-old woman from the "Non-theist Group," showed such an expression. When asked, "Have you become angry that God or whatever has left you?" she answered:

> No, not that God has left... I don't believe in God. But I sometimes thought like if there is a higher power, why doesn't it help me now, I believe I've thought. Or if there are higher powers, why don't these powers show themselves, when I…I really need them now, to have the support or a hint that…so that, more than that…Not that I'm mad at someone, rather that I wonder if they really exist, or if they exist if they have any power to change events. I was doubtful about the spiritual meaning of life, about everything non-material. I sometimes totally lost my trust in everything sacred.

Concerning the idea of viewing God and His power (Pargament 1997:357), different approaches to God have been found. The *secure approach* refers to the belief that God is always warm and responsive, the avoidant approach stresses the idea that God is generally impersonal and has nothing or little to do with personal affairs and the problems one faces and the *anxious/ambivalence approach* advocates the notion that God is seemingly inconsistent in His reaction to human beings. In this study, I have found among those who do not believe in God different ways of approaching the Spiritual Being. Some informants believed in a higher power who can change events, but not in the power depicted by religions. Others believed in a power that once created the cosmos unconsciously and then left it to itself and that, therefore, cannot exercise any power over the life of its creatures. Some believed in the idea that there exists a spiritual force in every person – an idea of the Unity of Existence. Those who belong to this group have shown an ambiguous attitude toward the Spiritual Being's ability to shape outcomes. The demarcating lines between these three categories were not, however, clear. It happened that, on different occasions, one and the same informant gave different pictures of this higher power. Facing a serious life crisis may affect individuals' attitudes toward God/a higher power and his/its ability to impact the situation. Being socialized in a society with a high de-

gree of secularism and rationalism augments the risk that a person will lose her/his belief in God or a higher power who can change events or her/his faith in all things sacred, as we saw in the case of the above-mentioned woman.

Spiritual Prayer

One coping method recognized in this study, called SRCOPE-*Spiritual Prayer*, involves seeking tranquility by praying, i.e. using prayer as a relaxation method or means of achieving calmness. Here, however, the act of praying differs from the conventional pleading to God for a miracle or divine intercession to make things better, as we see in one of the RCOPE methods, i.e. Pleading for Direct Intercession.

Two patterns are found in this study. In the first pattern, praying is a relaxation method, indeed a meditation. In the second one, the act of praying is a deep-rooted habit, which functions as a coping method and makes the individual feel safe and calm.

When asked if she prayed, the answer of one 57-year-old woman from the "Theist Group" illustrates the first pattern, i.e., praying as relaxation:

> No, I don't, but I... I can feel, you know when life is tough, and like now, then it can happen that I go and sit down and think…Actually it's a prayer, in my way, maybe. If it's you know, to a God or if it's some power that helps, it's kind of diffuse. But since I'm raised with it, well, it's somehow God we are talking about. But that it's some force who has to help me. There has been a lot of this kind of prayer nowadays, when I go through different treatments. And the last time was today when I thought about the specimens and this "good God, help me so that this doesn't continue with something new emerging". This gives me tranquility. But I don't pray regularly. I don't pray every night, I'm not one to pray. Not like that.

One 42-year-old woman from the "Theist Group" explained the same idea as follows:

> Didn't I pray to God to make me better? No, but I prayed in my way. You know, when I meditate I pray, I meditate of course when I'm well.

When asked if he prays, one 70-year-old man from the "Non-theist Group" answered:

> I might have prayed to a higher power… but this is something indeterminable to me. In my darkest moments... during the worst times… at night. One could say that.

The following dialogue with a 53-year-old man from the "Non-theist Group" presents the function of praying as a relaxation method.

I: You said that religion played a part in every treatment…can you talk a bit about it?

The interviewee: It has never been like I've prayed to get well or asked for a miracle...but I have asked for help to be part of the great force that exists. I have gone that far and that I've done before all treatments. But I've never asked for everything to be fine, I don't think you can pray for that. It gets to be as if you take away your own part in it all...and I am a part of this great force. That way I can also create it, not only get help from it. But praying has been important for my ability to face the difficult situation, a kind of relaxation pill.

While praying is seen as religious coping, meditation is usually regarded as non-religious coping. Some experimental studies (Elkins et al. 1979; Carlson et al. 1988) on the difference between the efficiency of religious coping and non-religious coping have tried to compare the efficiency of praying with that of mediation. However, in this study I found informants who had used praying as meditation. This may well be explained with reference to the fact that, as EVSS (European Value System Study) 1990 shows, in Scandinavian countries, especially in Sweden, "fewer believe in the traditional dogma of the churches whereas more associated with a diffuse, spiritual world view" (Riis 1994:107). On the other hand, we are witnessing the augmentation of a tendency toward a "New-Age religiosity", "i.e. belief in re-incarnation, a soul, a spirit force, and practicing prayer or meditation" (ibid.), or as we see among our informants, prayer as meditation.

When it comes to the second pattern, prayer as a habit, one 63-year-old woman from the "Non-theist Group" reported:

From childhood till now, I've done it every night. It's the last thing I do before I go to sleep. This is a habit that gives me peace, something for myself. It's just the evenings. When I was sick, I prayed as usual, but at that time other things entered the picture. At that time I had the fear. It was my inner feelings that entered back then… that you wanted to get well, and everything was going to be fine. I have always prayed, so I kept doing it but it took on a whole different meaning. It helped me deal with my illness. You know, I don't believe in God, but I believe, there is something… something exists, or otherwise we wouldn't exist… but I can't say to whom I pray. It's not a religious act; it's a routine that makes me feel good and relax.

One 31-year-old woman from the "Non-theist Group" stated the same idea when she was asked whether she used to pray:

I have done it, but it's not something I seriously believe will affect anything. It's only a habit I've had since childhood, or maybe many of us have, who turn to some higher power especially when we feel weak and fragile. But it's helped me feel calm.

In analyzing these citations I proceed from Pargament's discussion on the availability of religion in coping. As Pargament (1997:149) stresses, religion "is more likely to be accessed in coping when it is available to the individual, that is, when it is a larger part of the individual's orienting system for relating to the world". Regarding the second pattern, i.e., prayer as a deep-rooted habit functioning as a means for gaining safety and calmness, we are facing the availability of religion in the orienting system. As both informants stressed, they have been used to praying since their childhood, and though as adults they no longer believe in God, they have used praying as a means of relaxation. These informants turn to prayer for relaxation because praying is an accessible tool in facing difficult situations in their orienting system.

Self-Directing Coping

This study shows that several informants from all three Groups – the "Theist Group", the "Non-theist Group" and the "Atheists Group" – have chosen to rely on their individual initiative rather than on God's or someone else's help when seeking control over the difficult situation they have faced. Before presenting the results concerning this method, it should be mentioned that several informants from the "Non-theist Group" who have used Self-Directing Coping seem to associate it with a spiritual dimension. No such association with any spiritual dimension was reported among the informants from the "Theist Group" who have chosen Self-Directing Religious Coping. The use of Self-Directing Coping among the "Theist Group" was presented in Chapter 6.

I find an illustration of SRCOPE-*Self-Directing Coping* when a 36-year-old woman from the "Non-theist Group" explained her own role in the struggle she had with cancer:

> But it was important to me to feel that I could do something myself, not just be hanging on…Not waiting for a miracle from above or being like a vegetable, that the doctor says: now we'll do this and now that … I felt it was important for me to be able to influence things in some way. But I wanted to be honest with my doctor, and said I'd started getting help from alternative medicine, and he didn't like it at all. It was my belief in a life power, in something unexplainable that made me do it. I wanted to be part of my cure, in my way.

Another interviewee, a 64-year-old man from the "Non-theist Group" stated that:

> I believe that I, myself, can impact my life...I believe the mere fact that I can impact my life is itself a source of power, a spiritual force and this is happening in my body.

From the "Atheists Group", one 75-year-old man reported that:

> I believe only in myself. The only person who can help me, who can save me is me. The key is nothing more than a natural way of living. That one should not live in a fantasy world. Accept things as they are, live naturally, eat naturally. We should live in accordance with nature, since we are part of nature, which in turn is a part of a unity.

Another interviewee from the same group, a 61-year-old man, explained that:

> I thought I would never be able to handle my illness, but human beings are much stronger than we believe. I said to myself, I will not let this illness destroy me, not me. I decided not to let it. My decision gave me strength. "I will get my body back. I will handle it". This I repeated every time death looked me in the eye.

My impression is that all these informants have a strong tendency toward leaning on themselves to overcome the problems cancer had caused them. The point is that, in contrast to the informants from "Theist Group", who believed that God has given them the power to solve the problems themselves, these informants did not stress any belief in a power given to them by God, but in a power that they got from a spiritual force or nature or life itself. Whatever gave this power to them, they all aimed to be a part of their treatment and impact their life themselves. They wanted to be active in making a difference in their situation. I suppose that the strong tendency among Swedes toward solving their personal problems by relying chiefly on themselves and not on a higher power has played a role in the informants' insistence on coping with their illness by leaning on themselves. This would seem to be a result of having been socialized in a society characterized by secularism and individualism.

Spiritual Support

What distinguishes SRCOPE-*Spiritual Support* from RCOPE-Spiritual Support is that, in relation to the latter, people seem to look in times of stress for both comfort and strength in connection with God. In relation to the former, the focus is not on a search for comfort and strength through God, but on a search for love on the part of people who do not believe in God. I found two patterns in this respect. In the first pattern, which I called "*outworldly" spiritual support*, the patient seeks love from and through a Spiritual Being. In the second pattern, which I called "*inworldly" spiritual support*, the patient seeks love from and in relation to a "spiritual" person.

"Outworldly" Spiritual Support: The explanation given by one 33-year-old woman from the "Non-theist Group" concerning her search for love illustrates the first pattern:

> I sought love through a higher power. What was important to me was not getting support in that dark period, but just this feeling that we are part of something bigger, and love surrounds us. This made me to think more about the spiritual meaning of life and in this way prevented me from being stressed.

I see the search for love through a Spiritual Being as a search for meaning. We can see this clearly in the above citation. Our interviewee, in searching for love from a higher power, is searching for the meaning of life. This, in its turn, became a coping method when she faced the stressors caused by cancer.

"Inworldly" Spiritual Support: Regarding this pattern, one 47-year-old woman from the "Non-theist Group" stated that:

> So it was to get help from a spiritual person not from God. From someone who could make me feel I am loved. A priest who worked at our community church, but God, no. I don't believe in such a God who is sitting there and makes us happy or sad, sick or cured. Only love exists. I thought that the priest, whom I found to be a very spiritual person, can believe in God or whatever he wants, but for me he advocated love and peace. And these two I needed badly two years ago. I needed someone who could understand me, someone who did not expect me to be a good girl and be strong.

I see the search for love in relation to a "spiritual" person as a search for being loved, being understood. As our interviewee stresses, she wants to get help from someone who makes her feel loved. Thus, getting help from a priest was not actually a religious act, but a search for love from a spiritual source, a person she believed to be spiritual.

As I understand it, for some informants, it has not only been the thirst for love in the face of difficult events that has caused them to seek love from a spiritual person, but the act of searching itself has also been reassuring and comforting. The description given by one 57-year-old woman, from the "Non-theist Group," and her husband in their search for love from a mediator illustrates this point.

> There's a man in X who has a very religious meditative point of view. My husband and I wrote a couple times, some letters, to him, I've forgotten his name now. This man wrote back and said he didn't have time and was very busy, but he also said he was praying for me and things like that. And despite that, we kept writing one or a couple letters to this man and told him how things were going and what we had done and so on. I have thought a lot about our insisting on writing to him and seeking his love and support, despite getting no replies from him. Surely, a lot of times when you're lying there on the operating table or when you're experiencing something very

painful you need love from someone above. Like when you were a child and used to cry for help from your mother. When you do not believe in God, you can't call him "please God help me", then you seek a spiritual person, but often you know that it is only to diminish your stressor. When we wrote to that man, the writing and searching for love was itself a help, a way to deal with the fear of death.

As some researchers (Pargament 1997; Kushner 1989) maintain, religious faith and imagining a loving and supporting God can be a source of comfort and support for people facing a life crisis. In the framework of a culture like the Swedish, where there exists a kind of spirituality rather than religiosity among people, when a person facing a tragic event does not have faith and does not believe in God, the need for comfort may be directed toward a kind of spiritual support that is not necessarily religious. In this regard, one approach, as we saw in the case of the above-mentioned 47-year-old woman, is to see oneself as a larger form of "existence", a unity that surrounds the units within. One is no longer an isolated creature left alone to suffer without explanation. By ascribing a spiritual meaning to life and regarding oneself as part of an all-embracing life force, one may find comfort and strength. As some informants stressed, this may help the person make a spiritual "connection" with inner forces, in this way consciously transforming her/his reality.

Another approach reported by some informants is a direct search for love and tenderness that transcends interpersonal love. Unconditional and holistic love may help the person find answers to life's challenges and accept her-/himself and the current situation unconditionally. By searching for love, the person in crisis may develop an awareness of a higher level of consciousness that can help to expand her/his view of reality. This, in turn, paves the way for integrating conflicting issues within her-/himself and getting comfort. Here, the searching itself may even be a way to achieve relaxation.

Thus far, I have presented and analyzed spiritual methods – SRCOPE – that are in some way similar to some of the RCOPE methods. In the following, other spiritual methods that are not related to the RCOPE methods will be discussed.

Section Two:
New Spiritually Oriented Coping Methods
Dissimilar to RCOPE

In this section, the spiritual methods that are found in this study and are not related to the RCOPE methods will be in focus. These are Spiritual Connection with Oneself, Spiritual Sanctification of Nature, Positive Solitude, Empathy/Altruism, Search for Meaning, Visualization, Healing Therapy, Spiritual Music and Meditation.

Spiritual Connection with Oneself

As mentioned in the previous chapter, it was found that one RCOPE method, Spiritual Connection, was used by some informants from the "Theist Group". In using this method, the person looks for a stronger connection with God or a spiritual person. Another method used by some informants from the "Non-theist Group" has been identified that may be called *Spiritual Connection with Oneself*. Here, the person is not seeking spiritual connection with God or some other outworldly spiritual source, but she/he is looking for a spiritual connection with her-/himself. This is a search for an inner spirituality, which may help the person cope with the stress associated with illness.

I identified two patterns. In the first pattern, the patient aims at getting comfort and reducing her/his tensions and stressors through a spiritual connection with her-/himself. Regarding this pattern, one 48-year-old woman, when asked whether she ever had a feeling of strong connection with a higher power, answered:

> Yes, I have had it during my training. I used to do spiritual training. I've learned a lot from Buddhism. That in some way I have this spiritual connection with a higher power, if you like, but it's nothing but me. I have this force; I have, like Buddha, the spiritual power inside me. But then I don't really know how to use it. I only know that it has helped me pretty much deal with my illness. I was very depressed. It helps give me comfort. I feel better now.

One 43-year-old woman explained her search for a spiritual connection as follows:

> When I attended the rehabilitation program, there was a woman who would go through relaxation with us and talk about our bodies in a way that helped us relax different body parts. You were almost in a state of transcendence then. It was actually, a relation between your soul and your body. I have met her a few times. I was very impressed, I really listened. I can listen to a relaxation CD and really get into it. I found myself, my inner power, my soul.

> It was surely a spiritual experience, very effective in that period for dealing with this illness.

In the second pattern, the search becomes focused on finding the spiritual meaning of one's existence by rediscovering one's self. Concerning this pattern, one 42-year-old woman, when asked whether she has ever experienced a feeling of strong connection with a higher power, explained:

> Well, for one thing, I have had one of these experiences with natural scenery that I remember when I was in my 20s and it was then that I was suddenly totally changed, from being in a severe depression to being totally new. It was an amazing feeling. And I have had it recently too, when I've gone to this group therapy. I think it is mostly because I've really gotten in touch with the real me. And then I get in touch with this source that is there for everyone, inside, but you don't feel it if you look somewhere else, that all of us have a part of this higher force in us. I feel very secure and calm now, like when I was young and had that experience. I didn't know then that it was the force in me I got in connection with, now I know. I've found my way out of the depression I had. But this is not the point, in searching for a way out of my problems, I realized my self. I have found something much more precious, a meaning, and the spiritual meaning of my life.

In response to the question of whether religion has played a role in dealing with her disease, one 49-year-old woman from the "Non-theist Group" said:

> Religion, no. Spirituality, yes, if it means that you have an inner strength that helps you get through a disease and also faith in the future. Antonovsky's sense of coherence. Spirituality has helped me find my inner strength, but also why I am who I am and the meaning of my existence.

As we can see, finding oneself, respecting oneself, expressing ones individuality and searching for inner possibilities as well as actualizing the inner force may be a spiritual outcome. Like a religious person who sees something divine within the self, a non-religious but spiritually oriented person facing difficult events may search for the "sacred" in her/his self and find a force greater than the self – a source of strength. Here, we are neither witnessing "the incorporation of the sacred into the self" (Pargament 1997:253), as is the case in religious conversion, nor "dying unto oneself" or "loss of self" through unification with a greater existence, as in the case of self-inhibition (Ahmadi & Ahmadi 1998). What we are perhaps witnessing is what Fromm (1950) calls self-realization when he discusses "humanistic religion". In such "religion," the focus is on worshipping the power on which the individual relies. According to Fromm (1950:37), "Man's aim in humanistic religion is to achieve the greatest strength, not the greatest powerlessness, virtue is self-realization, not obedience". Through realization of the self when facing a stressful situation caused by illness, some of our in-

formants found a way to give a meaning to their life and, thereby, to cope with their illness.

Spiritual Sanctification of Nature

Concerning the spiritual connection, we have discussed two kinds of coping methods: one a search for a connection with God or a spiritual person used by some informants from the "Theist Group", the other a spiritual connection with oneself used by some informants from the "Non-theist Group". A third method, recognized in this study, is a spiritual connection with nature, which some informants from all three groups reported having experienced. In this study, seeking comfort in and a spiritual connection with nature is found to be one of the most important coping methods, called here *Spiritual Sanctification of Nature*.

Three patterns are recognized: coping by seeking spirituality *in nature*, as sought by some people in church, coping by seeking spiritual tranquility *through nature*, coping by having a spiritual connection *with nature*.

Regarding the first pattern, i.e. coping by seeking spirituality in nature, some informants reported that they viewed natural environments as *sacred* places, much like church. In this regard, one 48-year-old woman from the "Non-theist Group," when asked whether she used to visit church when she was ill, answered:

> No. I used to go out, into the woods. I walked outside a lot. I believe that there is more out there for me. The Church is beautiful. It has a good concert hall and all, nice, Christmas carols and so on; I think it's very nice in church. But a spiritual feeling of the kind some people get in church I get in nature, this feeling of the spiritual, you know.

One 53-year-old woman from the "Theist Group" answered the same question concerning church attendance as follows:

> Yes. But I don't go at all often anymore, probably once a month at the most. But I don't need a church to experience spirituality. I can become amazingly stimulated by a natural experience. Nature actually gives me more, taking a wonderful walk gives me more comfort and spiritual feeling than sitting in church. I rise with nature so to speak... I guess I carry that with me as a heritage from my parents, but after cancer, it happens more often that I go to the forest, outside, deliberately to find peace and tranquility. This has helped me a lot in finding my mental balance. I was very unbalanced after getting sick and had very turbulent feelings, which were quite dangerous for my health. Nature has cured me; I feel a spiritual affiliation with it.

Concerning the second pattern, coping by seeking spiritual tranquility through nature, some have actively sought tranquility and peace by means of nature as a remedy for their stressor. Here, what is in focus is not nature as a

sacred place, but the *spiritual feeling that nature grants to the person*. In this respect, one 35-year-old woman from the "Non-theist Group" explained as follows how nature has helped her cope with the difficulties she encountered while ill.

> I often went for walks. I enjoyed being outdoors, in the countryside or forest, in all weather. I have always been an outdoor person, so I can't say whether I became more so after getting cancer. But I know I experienced nature in a different way afterward. During that time, I discovered how little I was in this huge world, sort of like little me in the great whole. I got a special feeling out in nature. I got some sort of strength, I can't explain exactly what it was, but it was important for me to go out, otherwise I couldn't deal with that terrible situation.

One 29-year-old woman from the "Atheists Group" explained as follows the role of nature in fighting the fear and stressors her illness has brought about:

> Nature has meant a great deal. I've walked a lot in the woods. Before, it was more that I went jogging or did aerobics. But then I understood more and more that this was what I liked. I have come to understand things that I might have unconsciously felt even before, but now I have realized that this is what I want. So when I have been outdoors, first and foremost, I felt I was myself, that there was time for thoughts, it was peaceful, everything else disappeared. Whatever happens in the world to me or others, nature is still there, it keeps going. That is a feeling of security when everything else is chaos. The leaves fall off, new ones appear, somewhere there is a pulse that keeps going. The silence, it has become so apparent, when you want to get away from all the noise. It is a spiritual feeling, if we can use that word without connecting it to God, this is what I feel in nature and it's like a powerful therapy.

In the third pattern, neither nature as a sacred place (first pattern) nor the spiritual feelings nature offers (second pattern) is in focus. The focal point in the third pattern is a direct unintentional spiritual connection with nature, a feeling of being one with it. With respect to this pattern, coping by having a spiritual connection with nature, one 57-year-old man from the "Atheist Group," when asked whether he has ever had a spiritual experience, responded as follows:

> With nature, yes, one could say that it was spiritual. I used to walk in the forest near my house in the countryside. So what happened was that one afternoon, during the period when I was very sick, frightened and depressed, I went out walking on a path in that forest. The longer I walked on this path, the better I felt. There was a little lake and just as I sat down there, on a little bench, I heard a bird, a special bird chirping, and then it was just like a miracle. All my anxiety was gone, it was just like I was sitting inside a huge hand that surrounded me, and I felt I was cured. I was not cured of course, but it was a feeling, a beautiful unusual feeling. Mother Nature has shown herself to me. This was the first and maybe the last spiritual connection I felt. But it

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was quite enough. I walked back as a new person. I was no longer depressed. Some days after this happening, my doctor said I must be operated on again, it was an important operation but I didn't feel fear. It went well, the operation, but cancer, it can always come back. But I'm no longer frightened of death.

When asked whether she has ever experienced a spiritual connection with a higher power, one 35-year-old woman from the "Non-theist Group" answered:

No… but I think I felt it with a horse I was riding on. After losing my hair because of the chemotherapy, I wore a wig, but I used to take my wig off when I was riding and had a scarf or a hat on. Once I stood there and brushed the back of the horse when two girls entered and saw me without anything on my head and they said: "wow, how nice, your hair has grown out" and we stood there and talked and I kept taking care of the horse. Then the girls left and I felt how the horse slowly, slowly brushed my hair with its muzzle… I felt like he had understood that I had got my hair back… it was something special… it's hard to explain the feeling. I felt a special spiritual feeling, really strange feeling. It was very important for me to be able to get over some negative feelings I had in that period.

I discussed before the notion that people sanctify different aspects of life in their search for significance. Such a search becomes more important when we face a serious problem in life. As Pargament (1999:911) points out, virtually any object can be perceived as divine-like in character. I also mentioned that the sacred qualities include attributes of transcendence (e.g., holy, heavenly), ultimate value and purpose (e.g., blessed, inspiring) and timelessness (e.g., everlasting, miraculous). The above examples show that some informants perceived a sacred value in nature. For instance the above citation from a 29-year-old woman from the "Atheists Group" reveals how nature is given the sacred quality of timelessness when the interviewee points out that "So when I have been outdoors, …, it was peaceful, everything else disappeared. Whatever happens in the world to me or others, nature is still there, it keeps going. That is a feeling of security when everything else is chaos. The leaves fall off, new ones appear, somewhere there is a pulse that keeps going". Perceiving a circular recurrence process in nature that is timeless, the interviewee gives nature the attribution of a sacred object that despite all chaos and change is still there. By sanctifying nature as a timeless object, our interviewee, who is not a theist, finds a spiritual feeling that functions as therapy in his encounter with cancer.

It should be noted that none of the informants failed to mention having turned to nature during some period of stress or depression. Actually, as it seems, one of the most essential coping methods, used by all three groups in this study, is coping by seeking spirituality in nature, seeking spiritual tranquility through nature, or having a spiritual connection with nature.

One important factor in giving experiences with natural environments such a central role in coping is the prominent position of nature in Swedish ways of thinking and culture. Let us look at this point.

According to the Christian tradition, God has created human beings in His own image. Humankind, therefore, derives partially from a different substance than do other creatures. Many people, especially in Scandinavia, do not share such an understanding of the fundamental nature of humankind. In a survey based on interviews among 500 Swedes, while 66% of informants answered that "Human beings and animals have the same value," 27% answered that "human beings have a higher value than animals" and 7% were uncertain (Uddenberg 1995:26). Of those who believe in the same value of man and animal, 66% believed that animals have a soul and 77% were of the opinion that animals have self-consciousness and morality. Seventy-two percent thought that the emotional life of animals could be as rich as that of human beings (Uddenberg 1995:26).

Other studies give the same picture of Swedes' attitudes toward nature. According to EVSS (European Value System Study) 1990, 44% of one thousand Swedish informants were of the opinion that it is as important to save an animal species under threat of extinction as it is to save a human life (Uddenberg 1995:27). According to this study, 55 percent held the opinion that human beings and animals are equally valuable (Hamberg 1994:189, footnote 12). While 63% believed that "nature has its own value", only 37% agreed with the statement that "nature's value is in relation to its usefulness for man". Regarding environmental questions, 66% of the Swedish informants agreed that the struggle for the environment is urgent, and 38% admitted that they would accept tax laws aimed at preventing environmental pollution (Uddenberg 1995:27). An interesting point revealed through EVSS (European Value System Study) was that Swedes, more than other European peoples, are ready to devote themselves to and spend money on environmental issues.

In addition to EVSS (European Value System Study), other studies such as the Sifo study (Lindén 1994), the Uppsala Study of 1986 (Hamberg 1994) and the 1994 Study (Uddenberg 1995) all indicate that interest in nature and environmental questions is widespread among Swedes, especially among young people. According to the 1994 Study, based on a questionnaire survey among 973 Swedes between 20 and 69 years of age, only 4% replied that "we have no need to be out in nature", while 94% stressed that "nature makes them feel relaxed and harmonic". In the 1994 Study, 51% agreed that "human beings would feel much better if they were as natural as animals are".

In general, different investigations based on qualitative as well as quantitative studies show that Swedes have a tendency to erase the sharp borderline between humans and animals that is advocated by Christianity. What motivates Swedes in this regard is the idea that all creatures – among others

human beings –depend on one and the same ecological system, which incorporates and surrounds all living things. All beings are, therefore, dependent on each other and the idea that some are useful and some useless is therefore narrow and anthropocentric (Uddenberg 1995:34). The mark of the special position of nature in Swedish culture is what is called Allemansrätten (the legal right of access to private land), which means "that everyone has the right to move about freely in the outdoors, even on privately owned land. Certain restrictions apply….Allemansrätten is an ancient part of Swedish culture" (Herlitz 1995:35). Swedes' view of nature as a sacred and mysterious phenomenon and their strong tendency to visit natural environments, often experiencing a feeling of a unity with nature, presumably paves the way for the present informants' "turning to nature" as an essential way of coping with their stressor.

Positive Solitude

Preferring to be alone and to have the chance to contemplate is recognized in this study as one of the methods used by the Swedish informants to cope with the anxiety and stress caused by cancer.

Several informants mentioned that during this difficult time they have enjoyed being by themselves. I have chosen the term *Positive Solitude* for this attitude, which implies an appreciation of being alone. Some patients, all from the "Non-theist Group", reported Positive Solitude as the most important way to avoid exhaustion and to promote feelings of tranquility.

One 34-year-old woman from "Non-theist Group", when asked what made her feel tranquil when she was feeling poorly, answered:

> I liked very much being alone; remaining alone with my thoughts was the most essential way to deal with my problems. I've always liked being on my own, writing my thoughts down. Of course I liked being with other people too, but I liked being alone very much.

Another interviewee from the same group, a 53-year-old man, explained that:

> Now after being stricken with cancer, I can be sitting just watching the clouds for hours, not doing anything at all. We have a studio apartment here in town and I use to sit there on the upper floor looking out over the rooftops and then I felt so close to heaven. There I can sit and just watch without reading or writing… I get into a sort of expressionless neutral position, and that is wonderfully healing.

One 58-year-old woman, again from the "Non-theist Group", stressed that:

> When I'm in pain or not feeling well, I can be on my own too. I don't necessarily stay alone and I have people around me who always stand by me. I may still appreciate being alone, being on my own and listening to music or even reading a book.

Several studies, both qualitative and quantitative (Ahmadi Lewin 2001b; Tornstam 1997b; Tornstam 2005), show that there exists among Swedes a tendency toward positive solitude. Barinaga (1999:5) mentions that the positive connotation the word ensamhet (solitude) has in Sweden astonished immigrants who come from radically different cultures. As Barinaga stresses (ibid), the word solitude in Swedish suggests "inner peace, indolence and personal strength. It is a virtue already taught in early years of life". On the other hand, Helitz (1995) points out that, for Swedes, the idiom "att få vara i fred" (to be left in peace) does not merely imply the nice feeling of having time for oneself, but also entails being attentive of others' need for peace and positive solitude. Having respect for others' solitude is an important feature of Swedish culture. Such a need for one's own solitude and respect for others' solitude are based on the strong tendency toward individualism in the Swedish culture (Barinaga 1999:5). A Swede is expected to be able to do things by herself/himself and expects others to be independent and manage their own problems by themselves. Such being the case, we can understand why using positive solitude as a coping method was found to be prevalent among all groups in this study. In the framework of an individual-oriented culture that appreciates solitude, there is a good possibility that people facing a difficult event such as cancer will neither be frightened by or adverse to the idea of being alone with their thoughts and contemplating. This does not mean, however, that people prefer being left alone by friends and family. Naturally, Swedes like all other people, appreciate it when the people around them care about them in a crisis situation, and family, friends and work colleagues help them to feel better. What positive solitude means is that, for Swedes who appreciate inner peace, indolence and personal strength, one coping method is to sit alone, ponder and meditate – to be with oneself.

Empathy/Altruism

The word altruism comes from the Italian *altrui* and was first used by August Comte to refer to benevolence. What we call altruism is complicated, owing to the lack of agreement about many aspects of it, including its very definition. There are, however, several definitions of altruism in which seeking the welfare of others is seen as essential. Altruism has also been defined as self-destructive behavior performed for the benefit of others (Costello 2001). This definition, however, is not accepted by all researchers, because it does not allow for acts of altruism to include benefits to the actor. Although not everyone agrees with the idea that altruism can be completely pure, i.e.,

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without any reward for the actor, the definition that allows for benefits to the altruistic actor is generally accepted. This holds, however, only as long as that benefit is not a significant motivation, and as long as the benefit of the other is the main motivation. Accordingly, if altruistic behavior is motivated by the desire for future reward, it does not fit the generally accepted definitions of altruism. Human altruism is not only an act, but is interwoven with an emotion: empathy. Thus, it is difficult to identify a truly altruistic behavior independent of emotion. The attempt to separate altruism from empathy, or behavior from emotion, has not been terribly successful. According to researchers such as Damasio (2000), this is because there is a link between emotion and behavioral decision. In addressing such a link, Damasio (2000) argues against Descartes' notion of the separation of thought from bodily mechanisms. According to Damasio (2000), emotions are integral to the process of rational decision-making. In this study, proceeding from Damasio's view point and regarding empathy and altruism as an inseparable couple, I define this set as a voluntary intention/act to help others at some cost to oneself (time, effort or money).

Being a good person, fulfilling your responsibility as a human being and bestowing on the world what you owe it – based on a feeling of "unity of existence" and a feeling of connection with people all around the world – are found to constitute one of the methods used by some informants.

This method is reminiscent of one of the RCOPE methods, i.e. Religious Helping, which is considered an attempt to provide spiritual support and comfort to others. The difference between these two methods, however, is significant. As mentioned before, no informant reported having used Religious Helping. I drew this conclusion based on the informants' stated tendency toward privacy and refusal to involve other people when coping with a problem. As mentioned, one explanation for this tendency is that Swedes are very individualistic. Yet if individualism is a strong characteristic of the Swedish culture, then empathy and altruism is another side of the coin. Concerning SCOPE-*Empathy/Altruism*, the focus is not on responding to stressors by getting the help of/offering support to others or devoting oneself to others as is the case in Religious Helping; the motivation here is not religious. The issue is rather an abstract transcendent feeling, a feeling of Unity with all existence and, of course, a tendency toward empathy and altruism.

One interviewee, a 47-year-old woman from the "Non-theist Group," explained this method as follows:

> It's another sort of spirituality that I can feel. I have an amazing feeling for life, that life is so fantastic and something to treasure and respect. It's really awful this crisis in the world and when you see Bush on TV acting like a 6-year-old boy eager to begin a war somewhere in the world, you become frustrated, when life is so much more and so much bigger. There's so much evil in the world, and I wish goodness would get the chance to spread out instead. I wonder often about the people who live in desolation, wars, poverty, and

then I forget my illness. We are so protected, living in Sweden. My suffering from cancer is nothing in comparison with what human beings have gone through and are going through. I wish I could do something for just a few people. When you are sick you become very egotistical. I try to not be.

Another interviewee, a 42-year-old woman from the "Non-theist Group", explained how the idea of making the best of things has helped her cope with her disease. She said:

> I have an idea that I have this life now and that's what I know. And I want to make the best I can out of it. I want it to be so good, that I do the best I can during this life for me and for other people. And then maybe there isn't anything more. I'm not so interested in knowing if I will live several times, or if there is another world, at the same time I believe that life should somehow be about developing and finding myself, and my purpose in this world. Does that sound healthy; do you know what I mean? I mean we should find our "home". That "this is me; this is what I'm supposed to do. This is my contribution to the world". And if you haven't found it, you will walk around with a feeling of dissatisfaction, maybe your whole life. This has helped me, a lot, to go through all the problems my disease has caused.

As mentioned, there is a strong tendency toward individualism in the Swedish culture and ways of thinking. While a Swede tries to manage her/his own business by relying on herself/himself, she/he also has confidence in others' capacities and potential solutions to problems. Seen from a sociological point of view, this way of thinking leads to regarding an individual's failure primarily as a result of her/his own erroneous actions; individuals are responsible for their deeds. Such an individualistic view of human beings as free, independent, responsible and self-governing, however, does not prevent the existence of social solidarity with others' needs in the Swedish ways of thinking. As Barinaga (1999:5) points out, the idiom "*att göra rätt för sig*" (in English we would probably say "carrying your own weight") "perfectly pictures the moral dimension of Swedish individualism," which implies a "quest to be useful to the wide society, helpful to the abstract "other" rather than solely to the closest family as it is common in other societies". In other words, although on one level this concept implies that Swedes do not wish to owe anyone anything in terms of personal relations, on another level it is one of the cornerstones of the idea of the Swedish welfare system, i.e. a demand for security at the social level. Everyone should pay her/his share for creating a secure social system (Herlitz 1995:14-15). What is in focus is the improvement of *la Condition Humaine*. In order to "carry your own weight" and be the architect of your own happiness, the welfare system must enable people to live alone and be independent of family and relatives. The welfare system should provide each person with the means necessary for basic security regardless of personal wealth or kinship. According to Barinaga (1999:5), that Swedes accept such a high level of taxation is an expression of

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their social concern. To this we can add Swedes' enthusiasm for helping people around the world who are victims of injustice or catastrophes such as war, earthquakes, starvation, etc. What has had a great impact on the development of this enthusiasm is, among other things, the role of social democracy in shaping the Swedish culture. As Herlitz (1995:64) mentions "Social democracy has greatly influenced the shape of Swedish culture today. One contribution it has made has been to take strong measures to protect the weak, the frail, the poor and the vulnerable." This structured abstract solidarity with others and, as mentioned above, a strong feeling for all creatures demonstrate the tendency toward empathy and altruism in Swedish culture. Seen in this light, we have no difficulty understanding why being a good person and fulfilling one's responsibility as a human being may be used as a coping method among Swedes.

Search for Meaning

I have found that the search for existential meaning, i.e. pondering the meaning of life and death from a philosophical perspective, has functioned for some informants as a way to deal with their illness and to struggle against anxiety and depression.

Regarding SCOPE-*search for meaning*, one 79-year-old man from the "Theist Group" explained:

> It's pretty interesting to go back to, to what happened back then, in both the beginning and, well, then to you and your world. Experiences that you've had later on. There is a spiritual dimension of our existence that is of significance when you're in a difficult situation. But then when it comes to the dogmatist you could say there are some difficulties, but you should keep your faith. But it's different for me; I'm a human of the kind who analyzes and questions. It's not like you should have a fixed belief that takes you through difficulties in all situations forever, there is, well, another reality. I have read a lot and I'm very interested in outlooks on life and philosophy. A person who I'm pretty interested in is Jung and he is the father of the term synchronicity; well you do have experiences that are more or less unexplainable, kind of. My disease, which is on that level, so to speak. And this pondering, questioning, searching certainly has meant a great deal to me in handling the difficult situations I've faced; it has a spiritual character, I believe, and supports me when I feel desperate.

When asked "spirituality and religion how were they in the picture?" one 33-year-old woman from the "Non-theist Groups" answered:

> Spirituality, I think, has been important in dealing with my illness. Because I have devoted a lot of thought to, what is the meaning of life, what is the meaning of my being here? And in my depressive moments, when I have felt this dejection, I have wondered what cancer is, humankind's evil… you know, spirituality in that sense means that I've been a seeker, in some way

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looking for my kind of spirituality. I'm still seeking I guess. I don't really know where I'm heading, but I've always been very interested in views on the philosophy of life. In life and death, as I said.

One 36-year-old woman from the "Non-theist Group" reported that she regarded her being a searcher as a force – a force that pushed her forward in difficult situations when she felt she no longer had the strength to continue to live. She said:

> That it's such a driving force; it's always been a big driving force in my life. This searching, that I want answers to certain questions. The belief that you should learn a little bit every day, in every situation from life, that I'm not finished with that. And I think it's awfully exciting, at the same time. And I, somehow, during this lifetime, I want to get more into, and understand this, and accomplish something. I'm not done with life before then. That, it was such a big driving force for me to fight the cancer, to defeat it. I thought that now that I have cancer nobody can protest when I take time for myself, or to care for my body and soul and health. Instead, if I want to go to "healing" or weird courses, and other suspicious things, nobody says anything now, because now it's OK. It's sort of become a legit reason, this disease, to develop this part, and I think it's awfully exciting, or important, to understand. Now I try different kinds of healings and therapies. Because, not only do I want to be cured, but I'm also curious, and this, as my psychologist also said, has kept me from becoming depressed.

My understanding is that the disease has made these informants curious (or made them more curious than before) about the meaning of life and death. This has led them to a spiritual search for the answers to certain existential questions; this, in its turn, has become a force that functioned as a coping method for dealing with the problems cancer presented.

Throughout human history, people have tried to find meaning in their existence, the meaning of life and death. We can hardly find a religion that has failed to address the question of life's meaning. The dialogue between seeker and the divine, as Pargament (1997:48) points out, has been the focal point of much of the classic religious literature. Many studies (Paloutzian 1981; Rubin & Peplau 1975) show that people seek in religion an answer to their questions about the meaning of life and death. According to Geertz (1966), the most essential function of religion is to give meaning. But what about people who do not believe in God or who are not religious? How do they deal with the question of meaning, especially when facing a difficult event in life? One way of dealing with the problem of meaning may be to remain a seeker forever and to allow simply being a seeker to give your life meaning. It appears that for some informants, this has been the case. Being socialized in a rational and secular culture may prevent a Swede from looking to religious texts to find answers pertaining to the meaning of life and death. Yet, the tendency toward spirituality in Swedish ways of thinking means that it is

also not easy to satisfy a Swede with a simple materialistic answer. Remaining permanently a seeker may be meaning giving for some Swedes. As my study shows, pondering the meaning of life and death and other philosophical questions has become a spiritual force that gives meaning to patients' lives – a spiritual force pushing them forward in the stressful situation they faced. For some, their illness has become a reason to break free of certain boundaries that kept them from searching for alternative, non-conventional approaches to the problem of the relation between body and soul.

Holistic Health

Pargament and Mahoney (2005) mentions that viewed in the light of religion many aspects of life can be perceived as sacred in significance and character, including health, both physical (e.g. body as a temple) and psychological (e.g. sense of self, meaning). Our study shows that some informants, especially non-theists and atheists, perceive health as sacred and gave it special significance. It is in this respect that some informants turned to specific therapy techniques in coping with their illness. They reported using different techniques of holistic health or holistic therapy[1] to cope with their illness.

In holistic health, it is assumed that each person is a unified whole, with both mind and spirit playing important roles in healing the body. Holistic or "wholistic" health claims to approach all parts of the individual, not just the physical aspect where manifested illnesses are often most apparent. Advocates of holistic health believe that although it may very well be the physical component that is more easily recognized when problems arise, due to physical discomfort or pain signals, the mental, emotional and spiritual aspects also indicate imbalances and disease. Visualization or guided imagery, homeopathy, acupuncture, meditation, naturopathic medicine, energy-based therapies, prayerful intention, healing therapy, traditional Chinese medicine and many other techniques are among those used in holistic health to help the body heal itself.

Some researchers (Spiegel & Bloom 1983; Spiegel & Moore 1997; Boik 2001) as well as physicians and social workers (Fobair 1998) who deal with cancer patients maintain that, for people affected by cancer, complementary and holistic treatments have been shown to have particularly powerful effects in reducing pain and other side effects, boosting energy level and mood, and promoting overall improvement in the quality of life. As some psychologists and physicians stress (Friedman et al. 1997; Wyatt et al. 1999, Riner 1999), different holistic techniques together with conventional therapies play an important role in helping cancer patients gain control over fear and anxiety and in providing a better quality of life. When treatment is over, fear of cancer recurrence can take over and interfere with patients' quality of life. In such a situation, there is a great opportunity for healing – healing in

this case meaning gaining control over this gripping fear and anxiety. Notable in this respect is Dr. Spiegel's randomized study (Spiegel & Bloom 1983) showing the power of support groups for women with metastatic diseases. Most of these women received conventional medical treatment and also took part in regular support groups.

Applying holistic health as a complementary treatment is on its way to becoming an integrated part of health programs for different patients, especially for cancer patients. For instance, Stanford University provides for cancer patients a special program that includes some holistic health techniques[2]. Dr. Ernest H. Rosenbaum (2001), one of the pioneers in the development of the Cancer Supportive Care Program, has for more than a decade attempted to establish a national model for cancer supportive care – providing a wide variety of services that complement patients' traditional care. The Cancer Supportive Care Program at Stanford Hospital & Clinics, Stanford University Medical Center and some other hospitals offers care to cancer patients and their families that complements traditional treatment3.

In my study, some informants did report turning to holistic health. Visualization, healing therapy, music therapy and meditation were used as coping methods by these informants. The above-mentioned techniques did not, it appears, replace conventional treatment, but rather served as complementary or sometimes integrative therapy. In the following, these coping methods will be in focus.

Visualization

One of the holistic health methods used by informants is *visualization*. As Shafer and Greenfield (2000) explain, visualization is the language used by the mind to communicate and make sense of the inner and outer worlds. This technique, which is also called guided imagery, is supposed to promote physical, mental and emotional health by having the patient imagine positive images and desired outcomes of specific situations. Imagery, which refers to our awareness of sensory (physical) and perceptual (cognitive) experiences, has been used in a variety of health and healing practices in the Western world for over three decades (Heinschel 2002). The focus here is on thinking in mental images, or understanding the meaning of "pictures in the head" as it applies to health and well-being. According to Fournier (2000), one of the leaders of some courses on Guided Imagery provided for cancer patients by Stanford University, people dealing with illness are forced into a very focused state of mind; guided imagery takes advantage of that already focused state.

Visualization is a technique that is actually being used today in personal, professional and healthcare settings as a tool for stress management and coping. It can be defined as a mind-body intervention aimed at easing stress and promoting a sense of peace and tranquility in a stressful or difficult time

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in someone's life. The aim is to incorporate the "power of the mind" in order to help the body heal, to maintain health or to relax by way of inner communication involving all of the senses. It is thought that this technique forms a balance between mind, body and spirit. Visualization therapy is believed to encourage right hemisphere activity related to creativity and emotions.

According to some researchers (Shafer & Greenfield 2000; Epstein 1989), we have been witnessing for more than one decade an augmentation of interest in the practice of visualization, and the role of the imagination in health and well being, as an approach in treating a wide variety of psychiatric and medical concerns, as well as in enhancing sports performance. The principles of mental imagery, however, seem to have been utilized in healing since the beginning of medical history, though recent approaches to mental imaginary do differ from previous ones. Current pioneers embracing the scientific merit of mental imagery are transforming healing practices in Western medicine. This does not, however, prevent some researchers (Gawain 1995; Cooper 1999) from considering visualization to be a spiritual technique.

In Sweden, therapies based on visualization or guided imagery are not widespread. In the past few years, however, some professional and healthcare settings have begun to apply it. Some courses on relaxation therapy and guided imagery are provided for health professionals at different hospitals[4]. It seems that, in Sweden, visualization is not used as an alternative therapy, but as an extension of and complement to conventional medical practices.

In this study, I have found use of visualization as a spiritual method in struggling with the anxiety and fear that cancer can cause. Two patterns are found. In the first pattern, the patient uses her/his imagination to create a milieu where she/he can be tranquil. In the other pattern, the patient uses visualization as a form of therapy to help rid the body of cancer. Here, the idea is that bringing to mind a picture in which the tumor is vanishing will help the body fight the cancer. Regarding the first pattern, one 53-year-old man from the "Theist Group" explained that he has used imagining as a spiritually oriented coping method:

> I was home a long while, and then I became isolated, once for 35 days. Isolation was terrible. I am used to being outside in nature, and so isolation was a catastrophe. I have a good imagination; thus I could dream myself away. I could see trees from the window. I had a cycle exerciser, when things were really awful I rode the cycle exerciser and fantasized that I was riding in the countryside. For me, visualizing in this way was like going to church or meditating, it was a spiritual experience, a crucial way to struggle with my disease.

Another report concerning the first pattern was given by a 53-year-old woman from the "Theist Group". She said:

> I was out on a very delightful meadow, full of moss, soft and delightful and pleasant. And all over the meadow blue anemones and white anemones were growing. And then a white anemone grew tall and bent forward. And it became a shower. And it showered me, and then the white anemone said, "I'm showering away your cancer now". It comes by itself. I didn't try to force it at all. I was surprised myself when a white anemone came into my vision – where did that come from? It just came. I was sitting there in some kind of a semi-trance and feeling this is happening; my cancer is being cured with the help of a white anemone". It was like that, I saw it so clearly, I felt it very distinctly, it was a strong spiritual feeling. It was not like I tried to visualize it, like they say in books, I suppose, to get rid of the cancer cells, no it was like the white anemone created a feeling of being free from cancer, it was showered away by this spiritual feeling.

Here, as we see, the informants use their imagination to create a visualized milieu – a place like nature in the first citation above or a beautiful feeling like in the second one – that gives them the tranquility and peace they need to cope with their disease.

Visualization is not used by informants only for creating a psychological milieu for coping with cancer. Another pattern I found regarding the use of visualization as a coping method involved using it as a therapy for fighting the cancer tumor. In this regard, one 40-year-old woman from the "Non-theist Group" stressed that:

> The books helped me a lot, I read something called Hälsa och Mirakel (Health and Miracles), or something like that… it said that it is important to visualize when you are getting the radiation treatment... that it is blowing up the cancer cells. Every time, I was lying there I thought that way… now it's destroying the cancer cells. I read that in the book. I suited me to think that way. That your attitude is also of great importance in helping the treatment to take effect. When some people are sick thinking about God gives them strength, for me the thought that I can destroy the cancer cells through visualization gave me strength.

One 53-year-old man from the "Non-theist Group" described the same idea as follows:

> When you realize you have a life threatening disease in your own body… it gets more difficult to know how to deal with the tumor. It's part of your own body and it's difficult to start hating your own body, you need it to mobilize against the disease. Then I started to think that maybe you could remove the tumor from your body as an object using your mental powers… I practiced at that. Then I removed them from my body and fought them out there… and that's when I could visualize the tumors outside my body, as something independent of my body.

Another interviewee, a 34-year-old woman from the "Non-theist Group," discussed the role of visualization as therapy as follows:

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I'm about to start now and listen to a yoga tape I got from a friend. I've also thought that I must in some way give my body a spiritual kind of energy and this I do by visualizing the cell. Let me explain like this: I visualize the cell, we call it for instance x. When it enters my body, it begins to function like a spiritual force. And I imagine my body is like a garden of vegetables. I want to get rid of the weed. I walk around watering it with a sprinkling can containing, well, with the cell x containing a kind of spiritual force, which makes the weeds, the cancer cells vanish.

One 43-year-old woman from the "Non-theist Group," when asked whether religion had any part in dealing with her disease, brought up the role of visualization:

No, not religion. I couldn't say that. But that you do things with visualization and thinking in images. In that way you nourish your soul. You have more powers than you think. That's something I've thought about. I have an image in my head picturing a cell and I think of it. I believe in mankind's own powers… that you have powers you don't use… I don't think we're supposed to know all of our powers... we CANNOT know them. We have a healing body in a whole different way. There is a severe form of cancer that has been cured with… this Indian method… and I can believe in those kinds of things. You could call it mystique. Everything can't be explained, but we can bring a lot of awareness with positive thoughts. We can affect our body through visualization.

In contrast to the first pattern, in which visualization is used by informants to create a tranquil milieu for being able to cope with the stressor their disease has brought about, in the second pattern, visualization is used as a way to help rid the body of the cancer tumor. However, my understanding is that all informants who reported using visualization have used it as a complementary method to their conventional treatment. None of the informants stated that visualization had been recommended or was accomplished with the help of any professional, physician, psychologist or private therapist.

Visualization as a therapy is not the only therapeutic technique that is believed to help the body fight the cancer tumor. There are other techniques that are supposed to psychologically or physically aid the body in fighting cancer. The common name for these techniques is healing therapy.

Healing Therapy

During the past decade, cancer patients' tendency toward searching for techniques to help their body's healing abilities or to help them cope with treatment side effects has become stronger. These techniques are called healing therapy. Healing therapy encompasses a broad spectrum of natural and alternative therapies5. In all these techniques, the focus is on the ability of the body to heal itself naturally by spiritual as well as physical (or as they are

sometimes called "natural") methods. Some medical centers, such as Stanford University Hospital and the Psychological Laboratory at the Stanford University, have long provided different courses on healing therapy as complementary therapy for cancer patients and their families. There are still different opinions among physicians and cancer researchers as to the usefulness or harmfulness of such techniques. Although these techniques are not taught widely in Sweden, they are becoming increasingly popular and many of them are used in other countries to help cancer patients, though the application of healing therapy is confined mainly to a few private health settings. However, according to Wager (2001), who is a healing therapist, in Sweden the interest in alternative methods of treatment is growing. Acceptance – as well as use – is, however, still higher in the rest of Europe and in the US, even though attitudes in Sweden have changed considerably during recent years.

In this study, I found the use of healing therapy as a spiritually oriented coping method, called SCOPE-*Healing therapy*.

Some informants stressed the role of healing therapy in dealing with stressors caused by illness. In this respect, one 43-year-old woman from the "Non-theist Group" said that:

> I have used healing therapy in X (a private therapy center) for 8 months directly after the hospital treatment process was finished. I could never have recovered my health and strength without the healing therapy I got there, in X. It was a religious, no rather a spiritual experience for me, like for people who go on a pilgrimage.

My impression is that this interviewee does not claim directly that the healing therapy conducted in X caused her cancer tumor to vanish. However, her view of the effect of the healing therapy she went through is not limited to those effects a psychologist can provide people in a crisis. She viewed the healing therapy as a kind of spiritual miracle.

Another interviewee, a 63-year-old woman from the "Non-theist Group," explained:

> There were nurses and doctors and patients there, a couple who'd had breast cancer operations …then you felt a connection with them, I went to these groups, there we could cry, hug, talk and that is normal in that kind of situation. We felt solidarity…we were in the same situation…and somebody listened. It was pleasant; good food, dancing in the evenings and then we were out in the countryside, which is wonderful up there. This companionship with others was important, a kind of spiritual connection… you belong to a group… we sat in one room with an open fireplace and candles. The doctor read poems and outside it was dark and it snowed and it was so beautiful. The physician helped me with the medical aspects… but not with the emotional. That I got from the health home. There, I got spiritual support, which I didn't get in the hospital.

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Contrary to the previous interviewee, this interviewee, as I understand it, views the effect of the healing therapy not as a miracle that affected her body physically, but rather as a psychological/spiritual experience that helped her cope with her disease.

One 48-year-old woman from the "Non-theist Group" described how she benefited from healing therapy as follows:

> Then I said to my husband that now I'm calling X (a health center) and that became my "salvation". After fourteen days I came back as a new person. We were 20 women who had had breast cancer operations; we did gymnastics, talked and even prayed! I don't believe in God and praying was not part of the program, but we did it on our own initiative. It was strange, only a few among us believed in God. Actually, it wasn't praying to God that was the point, but the spiritual feeling we shared.

My impression is that the use of healing therapy by the informants in this study was generally connected with a spiritual feeling rather than superstitious beliefs or religious conviction. In all cases, it seems, informants have gained a feeling of spiritual support through healing therapy. It is perhaps for this reason the healing therapy used by the informants played the role of integrative therapy[6] (as in the case of the 63-year-old woman) or complementary therapy[7] (as in the case of the 43-year-old woman and the 48-year-old woman) rather than an alternative therapy.

Spiritual Music

One method reported by some informants as important in coping with the anxiety and stressors they have faced is listening to music. Informants also considered music to be a spiritual source as well as a healing method. Music therapy has functioned as a coping method for some informants. In this study, I called it *Spiritual Music*.

It is generally argued that music has the power to affect one's temperament and well-being. Some psychologists and therapists (Wheeler et al. 2003; Hanser & Thompson 1994; Knight & Rickard 2001; Hussey & Layman 2003) regard music as a valuable therapeutic tool that can decrease anxiety and tension, assist in pain management and promote relaxation. Music as a nonverbal means of expression is thought to be capable of reflecting the full range of human emotions. Although using music as a "healing" medium dates back to ancient times and in some countries, such as the US, began as early as the late 18th century, the modern principle of music therapy was founded during World War II, when it was widely applied to help soldiers recover from the mental injuries caused by the bloody war.

Music therapy is defined by the Canadian Association for Music Therapy (CAMT) as

the skillful use of music and musical elements by an accredited music therapist to promote, maintain, and restore mental, physical, emotional, and spiritual health. Music has nonverbal, creative, structural, and emotional qualities. These are used in the therapeutic relationship to facilitate contact, interaction, self-awareness, learning, self-expression, communication, and personal development" (Canadian Association for Music Therapy / Association de Musicothérapie du Canada Annual General Meeting, Vancouver, British Columbia, May 6, 1994. www.musictherapy.ca).

Music is generally regarded as a medium through which people may take steps toward developing their skills and abilities by virtue of relating, primarily in a non-verbal way, with others. Music is viewed, in this sense, as a manifestation of personality and interpersonal relatedness. It is supposed that the music therapist facilitates the individual's movement toward increased well-being by drawing on the individual's innate responsiveness to music. As music is non-verbal, it can bypass language, providing an alternative avenue for self-expression, exploration and communication of feelings. The interest in music as a therapy method in healthcare environments is growing all over the world. Researchers and clinicians (see, e.g., Aldridge 1993; Sammon 1997; Standley 2000; Marwick 2000; Cassileth et al. 2003) maintain that music therapy can improve health outcomes in different health areas such as surgery, cardiology, obstetrics and oncology. Increased relaxation, decreased anxiety and pain, and improved mood are some of the positive outcomes associated with music therapy interventions.

A number of publications have described the specific benefits of music therapy interventions for cancer patients. Interactive music interventions such as instrumental improvisation, drumming and singing have shown promise in improving the mood of cancer patients (Burns et al. 2001; Cassileth et al. 2003; Krout 2001). Some studies (Burns et al. 2001; Sahler et al. 2003; Tilch et al. 1999; Weber et al. 1997) have examined the effects of receptive interventions such as music listening, music and imagery or a combination of music therapy interventions on outcomes such as decreased pain and nausea, improved mood, increased family communication and improved quality of life among cancer patients. According to a report from New York's Memorial Sloan-Kettering Cancer Center, published 2004/01/08 on the website of the American Cancer Society, music therapy is used as a way to help cancer patients cope with the emotional distress often caused by high-dose chemotherapy and autologous stem cell transplantation. One study (Cassileth et al. 2003) shows that patients who were visited by a trained music therapist reported less anxiety and better overall mood than did patients who had not received music therapy. According to O'Callaghan (2002), when cancer patients are involved in musical re-play, they may have powerful experiences of identity affirmation, creative self-discoveries and a heightened sense of feeling and experiencing one's "real" and "alive" self.

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One of the consequences of the studies on music and oncology has been the use of music in care programs at certain cancer centers. For instance, based on the results of studies (Standley 2000; Smith et al. 2001; Hilliard 2003) on the effect of music on the well-being of cancer patients, the Stanford Cancer Center (affiliated with the Stanford Hospital and Clinics) provides a special music therapy program for cancer patients[8].

During recent years, there has been increasing interest in receptive music therapy models in the Nordic countries. This increased interest in music therapy and in using guided imagery and music together is reflected in a peer-reviewed journal – the Nordic Journal of Music Therapy – published biannually in Norway. The journal covers music therapy in Denmark, Finland, Iceland, Norway and Sweden and the Baltic Countries of Estonia, Latvia and Lithuania. In Sweden, the Swedish Association for Music Therapy has been active since 1974. Although, music therapy is now an established treatment method for some groups with certain health problems such as disabled children (Swedish Government Official Reports 1988:62), there are no studies that shed light on the effects of music on coping with a serious illness.

As mentioned above, in this study some informants reported having used music to cope with their illness. Two patterns of using music as a coping method have been found. In the first pattern, music is regarded as a spiritual source and its important role is in connection with its religious signification. In the second pattern, music's function as a healing method is in focus.

One 68-year-old woman from the "Theist Group" answered the question of what helped her cope with the stressors as follows:

> My feeling of security and my faith, but there were also other components such as music. It goes hand in hand with my belief. I feel that music and the belief I have belong together. I could not live without music and it has also followed me through my whole childhood… playing music, having a lot of kids – I like being a producer and having concerts with children – have helped me since I got cancer. I feel that music gives me more than everything else. Music is as important as my faith; I can't be separated from either of these two things, everything else but not these two parts of my life.

As mentioned above, Pargament and Mahoney (2005) consider that many aspects of life can be perceived as sacred in significance and character. Sanctification of music may be a way of coping with the stressor one faces in cases of difficult illness. One good example in this regard is the above citation of the 68-year-old woman, from the "Theist Group", who stressed that "I feel that music and the belief I have belong together. I could not live without music… Music is as important as my faith; I can't be separated from either of these two things, everything else but not these two parts of my life". Here, our interviewee, by means of sanctification of music, finds a way to handle the difficult situation caused by her cancer disease. My impression is

that, for this interviewee, music played the role of a spiritual source, which strengthened her psyche making her more powerful and able to deal with cancer.

Regarding the second pattern, i.e. music as therapy, one 36-year-old woman from the "Non-theist Group" explained:

> The music I listen to has been more the kind you can buy at the health store, a spiritual kind of music, which has more of a healing character, such as Indian healing music. And yes, even him, Depak Chopra; he has a few with this kind of Ayurvedic music. This kind of relaxing music has been a big help to me – helped me feel tranquil; it was a sort of therapy making me mentally prepared to face difficult situations like the operation and chemotherapy, even after treatment it has helped me a lot.

The description provided by one 65-year-old woman from the "Theist Group" of her experience with music therapy also illustrates the second pattern:

> I applied to a music therapist distance course in Uppsala. Then I studied music therapy for a year. It's so positive, the kinds of courses I can later share with others. It strengthens my knowledge and my experience. It was fun; we were from different parts of the country, but we act individually. It functioned as healing therapy, of course, not a traditional therapy, but a new one, through music. I found it very useful and I try to inform cancer patients about its effect.

One interviewee, a 79-year-old man from the "Theist Group", when asked what helped him find his way out of depression, answered:

> Spiritual music and so on, which is another connection to spiritual reality. It is probably more likely that the music, the spiritual church music, and the spiritual songs gave me the strength I needed when I was very ill, even now. When I was depressed, hymns meant something special to me, I have mentioned before Natanael Beskow, but there were also others who I willingly read, they are often in the form of prayers and they became a kind of personal prayer for me. Music was my way out of anxiety and depression.

My understanding is that, here, music in itself is not a spiritual source. Rather, by causing the informants to feel tranquil and helping them to overcome the depression and other psychological problems the cancer caused, music has imparted a spiritual effect.

Meditation

Meditation is one of several relaxation methods, an exercise, aimed at prevention of thoughts in a natural way, through deeply relaxing the physical body and then trying to keep the mind completely "blank" with no thoughts

whatsoever. This is indeed a mind-body process that uses concentration or reflection to relax the body and calm the mind in order to create a sense of well-being. There are various types of meditation – prayer, transcendental meditation, mindfulness meditation, and from the Eastern tradition, Zen meditation, Buddhist meditation and Taoist meditation. All types of meditation focus on quieting the busy mind. The purpose is not to eliminate stimulation, but rather to direct concentration to one healing element – one sound, one word, one image or one's breathing. When the mind is at peace, it can hardly be stressed or get depressed. According to some researchers (Barnes et al. 2001; Maclean et al. 1997), meditation can contribute to an individual's psychological and physiological well-being. It is claimed that meditation can reduce blood pressure and relieve pain and stress.

During the past decade, we have witnessed an increase in the numbers of physicians and psychotherapists, especially those dealing with cancer patients, who have added meditative techniques to their practice. There is no scientific evidence, according to the NIH National Center for Complementary and Alternative Medicine, that meditation is effective in treating cancer or any other disease (www.cancer.org/). Mediation can, however, help to improve the quality of life of people with cancer (Coker 1999; Spencer et al. 1998). It seems that, in Sweden, practicing meditation in relation to health problems has become more widespread during the past decade.

Although meditation can be used as a simple relaxation technique, it is undeniable that there are signs of spirituality in meditation. Many types of meditation are regarded as spiritual ways of gaining access to a Higher Self. In this regard, the purity of mind achieved during meditation is regarded as essential. A sense of spirituality together with a feeling of relaxation can cause meditation to play the role of a coping method.

One of the methods found in my study and used by informants as an effective spiritually oriented coping method is meditation. I called this SCOPE- *Meditation*. One 48-year-old woman from the "Non-theist Group" said in this regard:

> Well, this is about meditating every morning and night. We have a locker with writing inside, where this "mantra" is written. And this "mantra" is in fact nothing other than us. So all of this is us from top to bottom, and it exists in the universe. And I believe in this, the law of the universe, I mean...there is a law that exists in the universe… if you believe with your body, and heart, and then it works as well as other therapies. Meditation is not a way of clearing your thoughts. No, meditation is rather a way of exposing your thoughts. Meditation has given me the spiritual strength I needed, I mean to deal with cancer.

One 53-year-old man from the "Non-theist Group" stressed meditation as one important method in coping with his illness. He reported:

> Meditation, visualization, contemplation, the art of doing nothing, these are my ways of coping with cancer. Meditation has been a big help. It gives me not only mental health – I mean the concentration you need when you feel stressed. But it also gives me spiritual strength.

People can use meditation in different ways in coping, as a relaxation method, as a way to attain spiritual power or as a way attain their own inner power. My impression is that the informants above did not use meditation only as a relaxation technique, but also as a way to attain the spiritual power to cope with their disease.

One 36-year-old woman from the "Non-theist Group" explained how meditation has helped her in her struggle against cancer by helping her to find her inner power and inner self:

> I see spirituality as a path to health and survival. Meditation is a way to practice it. Before it was more like I wanted answers and it was exciting and it was more... How can I know what my task is, and what's right and wrong? And I must get answers to questions. I must understand the world, but now, after experiencing cancer, I believe, in order to live in harmony and to regain my health I must have a spiritual root. I connected it to my health, in a different way now, after this. I believe that, if I'm to become well, I must be in touch with my inner self. Meditation helps me to find myself.

According to some researchers (e.g., Maldonado 2003), it seems as if techniques such as intercessory prayer, healing touch and the like, which have religious characteristics, are mainly used by people of faith. On the other hand, techniques such as meditation, visualization, acupuncture are usually used by educated middle-class people who are not used to practicing their religion actively or who are not religious at all. As we have learned, there exists among Swedes a strong tendency toward spirituality rather than religiosity and especially toward what is called "private religion". If we add to this tendency Swedes' enthusiastic interest in nature and holistic view, and if we recall that during the past decade the materialistic view of life has lost its absolute position in the ways of thinking of Swedes, giving way to postmaterialism, we can understand why holistic health has possibly found fertile soil in Sweden and why interest in different alternative therapies has increased during the past decade.

Summing up in this chapter, I have presented and analyzed the new coping methods I found among the Swedish cancer patients in this study. These methods are found to be different from the methods categorized as RCOPE; a number of them had some similarities with some of the RCOPE methods and several were not related to the RCOPE methods. Common to all methods was that they expressed a kind of spirituality connected with coping. Although we related these new methods with certain characteristics of the Swedish/Scandinavian culture, such methods are presumably not used only

by Swedes. There are reasons to believe that application of these methods can be found among other peoples, especially those who practice their religion in a non-organizational way and who are more spiritually than religiously oriented.

In the next chapter, I will present findings touching upon the "gender-directed" and "age-directed" character of coping, i.e., differences between men and women as well as differences between divergent age groups in their choice of religious and spiritually oriented coping methods.

Notes:

[1] In different texts, Holistic Health is also called Alternative Medicine, Complementary Medicine, Holistic Healing or Integrative Medicine. Yet there are certain reliable and scientific definitions of some of these labels. Complementary and alternative medicine (CAM) are defined by the National Center for Complementary and Alternative Medicine (NCCAM) as a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. Complementary medicine is used together with conventional medicine. Alternative medicine is used in place of conventional medicine. Conventional medicine is medicine as practiced by holders of medical doctor or doctor of osteopathy degrees and by their allied health professionals, such as physical therapists, psychologists, and registered nurses.
The American Cancer Society Operational Statement on Complementary and Alternative Methods of Cancer Management on August 12, 1999 stresses, however, that "Alternative methods are defined as unproved or disproved methods, rather than evidence-based or proven methods to prevent, diagnose, and treat cancer. "Complementary" methods are defined as supportive methods used to complement evidence-based treatment. Complementary therapies do not replace mainstream cancer treatment and are not promoted to cure disease. Rather, they control symptoms and improve well being and quality of life. This distinction separates methods based on how they are promoted and used" (see www.cancer.org). Integrated or integrative care or therapy is used when complementary and conventional therapists work together.
[2] See http://www.stanfordhospital.com/clinicsmedServices/clinics/complementaryMedicine/index.html
[3] The supportive care program principles are espoused by many authorities, including David Spiegel, MD, Professor of Psychiatry and Behavioral Sciences, who reported in 1989 that breast cancer patients involved in support groups lived longer than patients who did not attend such groups. Spiegel is Medical Director of the Complementary Medicine Clinic.
[4] "Relaxation Therapy and Guided Imagery: A Paediatric Pain Intervention for Health Professionals". Short course conducted at Astrid Lindgren's Children's Hospital, Stockholm, Sweden, in September 2000 and March 2000. The same course was conducted in 2002 at Astrid Lindgren's Children's Hospital, Stockholm, Sweden, and in May 2002 at Queen Silvia's Children's Hospital Gothenburg.
[5] Acupuncture, the Alexander Technique, Applied Kinesiology, Aromatherapy, Pilates, Colonic Therapy, Craniosacral therapy, Energy healing, Feldenkrais, Feng Shui, Yoga, Naturopathy are among such techniques. For more information on these techniques see for instance: www.complementary-healthcare.co.uk.
[6] Integrated or integrative care or therapy is used when complementary and conventional therapists work together.
[7] Complementary medicine is used together with conventional medicine.
[8] For more information see: http://cancer.stanfordhospital.com/healthInfo/alternativeTherapy/senses/.

Chapter 8: Gender and Age Differences

Although my study does not have as one of its main focus areas the role of gender and age in coping, I do not disregard the impact of gender and age. It is obvious that gender and age are complicated phenomena, which deserve particular attention when studying their role in coping. My aim in studying the role of gender and age in this study, however, was limited to a preliminary overview, to see whether there is any difference between the religious and spiritually oriented methods used by different age groups and by men as compared with women. I have therefore not set out to conduct a complicated analysis of the role of these two components in religious and spiritually oriented coping. Such an endeavor would require another study with more specific gender- and age-oriented questions.

In relation to these factors, findings and analyses touching upon the following questions will be in focus in this chapter:

1. What role does age play in the choice of religious and spiritually oriented coping methods used by cancer patients in this study?
2. What role does gender play in the choice of religious and spiritually oriented coping methods used by cancer patients in this study?

In the first section, I will first present a review of the study on religious and spiritually coping with a focus on age. I will then focus on age differences in the coping methods found in my study. In the second section, I will first present a brief review of previous studies on gender differences and religious and spiritually oriented coping. Following this introduction, the present findings on gender differences in the coping methods will be presented and analyzed.

Given that this is a qualitative study, it is naturally difficult to draw conclusions based on comparisons between different age and gender groups concerning the extent to which divergent religious and spiritual methods are utilized. It is also difficult to generalize the results of this study and to make any reliable statements about the magnitude of differences. What we may do, however, is shed light on certain tendencies and state hypotheses concerning the raison d'être of any established tendencies. Showing such tendencies is, of course, a necessary step for future survey studies on the prevalence of religious and spiritually oriented coping strategies in cultures such as Sweden, where religion does not play a decisive role in people's social life.

Before presenting my results on age and gender differences in the use of religious and spiritually oriented coping methods, I present, in Table 5, some information on the study sample as a function of gender and age. Recall that 18 men and 33 women between 25 and 83 years of age participated in this study.

Table 5. Sample age and gender

Age						Age at diagnosis						Outlook on life					
18-40		41-64		65+		18-40		41-64		65+		Theist		Non-theist		Atheist	
M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W
0	10	10	21	8	2	2	14	12	18	4	1	6	8	5	22	7	3

M= Man W= Woman

Age Differences in Coping

Review of Studies on Age, Religiosity, Spirituality and Coping

Religion and Aging

Researchers usually suggest that religious beliefs and spiritual experiences may take on a larger role as a personal resource/support with increasing age (see, e.g., Koenig et al. 1988b; Ellison 1991; Boudreaux et al. 1995). This is in line with the popular view that religious faith becomes stronger as frailty increases and death approaches. But is this true? Do religion and spirituality always positively affect well-being in later life and can religion and spirituality be considered coping mechanisms for all elderly people?

As Coleman (1992:23) maintains, when growing into old age, religion "may gain in meaning for some, but lose it for others. For some the struggle between doubt and faith may become more intense". In a study (McCulloch 1985) conducted among elderly people in Southampton, almost half of the sample of 100 people said that they found it difficult to maintain the traditional religious beliefs they had been brought up with. The experience of religious questioning among the elderly is also considered in other studies (Coleman 1992).

On the other hand, Koenig's (1993) and Moberg's (1996) studies do show that religious belief and practice are more common among older adults. In Koenig's study of 500 medical patients, 68% were over the age of 70. Of these, 60% indicated that their religious beliefs and behavior had increased with age. Koenig put forward two hypotheses to explain this trend: Either people become more religious as they age, or they have always been more religious because they grew up in a family or culture in which religion was more dominant than it is today. The first hypothesis can hardly be defended, as some studies call into question the tendency toward growing religiosity with age (McCulloch 1985; Coleman 2000; Coleman 1992). Scott (1998:9) indicates that, to provide support for the second hypothesis, we must have "much more information on childhood family values and religious practice than can possibly be provided by a cross sectional study". Using data from Gallup polls and a longitudinal study, Moberg (1996) debates the age-period-cohort issue. He argues that even if older people experienced more religious training during childhood than more recent generations have experienced, no decline in the religiosity of successive generations of older people is found over a half a century to prove it was a cohort effect. As Scott (1998: 9) mentions, "Moberg finds the web of period effects so tangled that he is unable to identify any pattern of events which has made the oldest generation more religious than others". There is another possibility that, according to Scott (1998: 9-10), is overlooked by both Koenig and Moberg – that people may become more open about their religious beliefs as they age. Here Scott takes advantage of Marcoen's (1994) suggestion that "old age is

the touchstone of the spirituality which one has adopted or discovered over years" (Scott, 1998: 10). A forth possibility, which has not been taken into consideration in discussions on aging and the tendency toward spirituality, is the development toward *gerotranscendence*.

According to Tornstam (1994; 1996; 1997a; 1997b, 2005), human aging, the very process of living into old age, is characterized by a general potential toward gerotranscendence. From the perspective of late-in-life development, gerotranscendence is regarded as the final stage in a natural progression toward maturation and wisdom. According to the theory of gerotranscendence (Tornstam 2005; Tornstam 1996), the individual moving toward gerotranscendence may experience a series of changes. The gerotranscendent individual typically experiences, according to Tornstam (2005, 1996), a redefinition of Self and of relationships to others, as well as a new understanding of fundamental existential questions. Tornstam (1989:55), in his very early discussion on the theory of gerotranscendence, maintains that gerotranscendence "can be described as a shift in meta-perspective from a materialistic and rational view to a more cosmic and transcendent one". Regarding the relation between religion and gerotranscendence, as Thomas (1997b:14) stresses, the theory of gerotranscendence "does not assume that Gerotranscendence is necessarily connected with religion" – it is posited that gerotranscendence "is a naturally occurring phenomena with age, subject, of course to cultural influences in the way it is manifested and interpreted".

As studies (Ahmadi 199; Ahmadi & Thomas 2000; Ahmadi 2000a; Ahmadi 2000b; Ahmadi 2001) on the impact of different cultural settings on gerotranscendent development show, there is fertile ground for development toward gerotranscendence among individuals irrespective of whether or not they are religious. Regarding this, if an informant tells us that she/he has become less self-occupied with aging and has experienced a decreased interest in material things and a greater need for solitary "meditation", if she/he feels a cosmic communion with the spirit of the universe, if she/he redefines time, space, life and death in a different way than she/he used to do, we cannot be certain that she/he is expressing an increasing tendency toward religiosity with aging. She/he may be describing a cosmic transcendence caused by growing into old age, a gerotranscendent experience. This point has been taken into consideration in this study.

In this study, as discussed before, the focus was on investigating the religious and spiritual coping behaviors in the context of cultures, such as the Swedish one, in which people practice their "religion" in a spiritual, subjective, non-organizational way, rather than in an organizational way. As I explained before, I have chosen a definition of spirituality that focuses on spirituality experienced in a religious context as well as outside the religious sphere and that targets individuals who rise above the banality of everyday life and experience a cosmic view of life. Given the above discussion on gerotranscendence, it has hopefully become clear that a gerotranscendent

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experience may well be categorized as a non-religious spiritual experience. Thus, in my study, I have considered this point by distinguishing between a religious spiritual coping method and a non-religious spiritual one – perhaps a gerotranscendent one.

Religious and Spiritual Coping among Elderly

Some investigations have provided evidence of a relationship between age and religious coping (McCrae 1984; MacFadden 1995; Kimble et al. 1995; Levin 1994; Schaie 2004). For instance, in Conway's study (Conway 1985-1986), religion is cited more frequently than any other resource for coping by minorities, the elderly and individuals facing a life-threatening crisis. There are, however, other studies that do not provide any evidence for a relationship between age and the degree of religious involvement in coping (Pargament et al. 1995:53). In this regard, Pargament et al. (1995:52) state that while literature

> indicates that religion is an important part of the way the elderly deal with difficult times, it does not say that the elderly use religious coping methods more than their younger counterparts.

Some studies, among others the Project of Religion and Coping, have provided support for the idea that it is *the kind of religious coping* rather than *the amount of religious coping* that changes with age (Pargament et al. 1995:53). For example, it is found that "old people were more likely to use spiritual-based ways of coping" (ibid.).

Moreover, some hypotheses claim that religious and spiritual approaches to copying may be more helpful to some kinds of elderly people than to others, and that some types of religious and spiritual copying strategies are more helpful to the elderly than to others (Kurleychek 1976; Pargament et al. 1995).

One of the problems of studying spirituality and aging has been the paucity of literature on the subject in Sweden. As books and journals show, most of the active research has been conducted in the US. The limited number of journal articles available, however, cannot truly reflect the elderly population, and it may not be culturally appropriate to apply research findings to them. Thus, it is not a fallacy to maintain that systematic studies of the use of religious coping strategies among the elderly are still in the very early stages of development and incorporation into the analysis of religion and coping. Grounded in the area of gerontological research, the present study tries to explore the role of age in the use of religious and spiritually oriented coping methods in the context of those societies where spirituality is more prevalent than religiosity.

After a short introduction of several studies on aging and religious coping, I will focus, in the following section, on the age differences found in this study concerning the religious and spiritually oriented methods used.

Results Concerning Age Differences

Age and Religion

As mentioned before, there are studies showing that religious belief and practice are more common among older adults than among the younger generation. Our study shows that older people use different types of religious coping more than do other age groups. We said that there are four hypothetical possibilities that are able to explain why older people show a greater tendency toward religion than do younger people: One is that people become more religious as they age, and the second is that they have always been more religious because they grew up in a family or culture in which religion was more dominant than it is today. The third possibility is that people may become more open about their religious beliefs as they age, and the forth concerns development toward gerotranscendence. My study was not designed to examine such hypotheses. It does show, however, that just as when the individual moves toward gerotranscendence, when she/he is stricken by cancer and is struggling with the crisis involved, there is a possibility that she/he will experience a redefinition of Self and of relationships to others, as well as a new understanding of fundamental existential questions. This is in accordance with findings from Tornstam's study (1997c:130) on life crises and gerotranscendence. According to this study:

> Subjectively experienced crises in life seem to contribute to the development of cosmic transcendence, especially among women… The feeling of coherence and the need for solitude are also affected by the experience of life crises.

Statements made by some of the informants in my study were similar in some respects to those made by people interviewed in relation to the theory of gerotranscendence. For instance one of the informants in my study stressed that:

> I am happy that I live now and my life is not finished after being stricken by this illness; I am alive now. I appreciate life every day. Before being stricken by cancer, I took life for granted. I took my good health for granted. I had been in good health almost my entire life. I had not had any serious health problems. But now I appreciate health, life, everything around me. This illness has radically changed me and my view on life.

It should be mentioned that some of the SCOPE methods, such as Positive Solitude, Search for Meaning and Altruism, are reminiscent of certain gero-

transcendence dimensions. But I could not find any evidence showing that the use of these methods is related to age and being gerotranscendent. The first two methods are used by all age groups, and the last one only by the age group 41-64 years. Generally, I could not find in the present material any evidence to support the notion that informants have used certain religious or spiritual methods due to their being gerotranscendent.

Religious and Spiritually Oriented Methods

RCOPE Methods: As illuminated in Chapter 6, the following RCOPE methods are found in this study: Benevolent Religious Reappraisal, Collaborative Religious Coping, Pleading for Direct Intercession, Self-Directing Religious Coping, Seeking Spiritual Support, Religious Focus, Spiritual Connection, Spiritual Discontent and Sanctification of Nature. In Table 6, we find those RCOPE methods that are used by different age groups.

As Table 6 shows, the age group 41-64 years is the only group that used all of the different RCOPE methods as well as the additional method found in this study, i.e. Sanctification of Nature. The use of RCOPE methods, as the study shows, was limited among the age group 18-40 years. Three methods are used by all age groups. These are: Spiritual Connection, Pleading for Direct Intercession, Self-Directing Religious Coping.

SRCOPE methods: Methods that are here called SRCOPE are: Punishment, Benevolent Spiritual Reappraisal, Collaborative Spiritual Coping, Spiritual Discontent, Spiritual Prayer, Self-Directing Coping and Spiritual Support. Table 6 indicates differences found across age groups using SRCOPE-methods.

As shown in Table 6, there is no difference between age group 18-40 and age group 41-64 concerning the use of SRCOPE methods, but considerable differences between these two groups and age group 65+. The use of SRCOPE was limited among age group 65+. The SRCOPE methods Collaborative Spiritual Coping and Spiritual Prayer were used by all three groups.

Table 6. Age differences

18-40	41-64	65+
RCOPE		
Religious Focus	Religious Focus	Religious Focus
Spiritual Connection	Spiritual Connection	Spiritual Connection
Pleading for Direct Intercession	Pleading for Direct Intercession	Pleading for Direct Intercession
Self-Directing Religious Coping	Self-Directing Religious Coping	Self-Directing Religious Coping
---	Seeking Spiritual Support	Seeking Spiritual Support
---	Spiritual Discontent	Spiritual Discontent
---	Collaborative Religious Coping	Collaborative Religious Coping
---	Benevolent Religious Reappraisal	Benevolent Religious Reappraisal
---	Sanctification of Nature	Sanctification of Nature
SRCOPE		
Punishment	Punishment	---
Benevolent Religious Reappraisal	Benevolent Religious Reappraisal	---
Collaborative Spiritual Coping	Collaborative Spiritual Coping	Collaborative Spiritual Coping
Spiritual Discontent	Spiritual Discontent	---
Spiritual Prayer	Spiritual Prayer	Spiritual Prayer
Self-Directing Coping	Self-Directing Coping	---
Spiritual Support	Spiritual Support	---
SCOPE		
Spiritual Connection with Self	Spiritual Connection with Self	---
Spiritual Sanctification of Nature	Spiritual Sanctification of Nature	Spiritual Sanctification of Nature
Positive Solitude	Positive Solitude	Positive Solitude
---	Altruism	---
Search for Meaning	Search for Meaning	Search for Meaning
Visualization	Visualization	---
Healing Therapy	Healing Therapy	Healing Therapy
Spiritual Music	Spiritual Music	Spiritual Music
Meditation	Meditation	Meditation

SCOPE methods: As mentioned in Chapter 7, besides RCOPE methods and SRCOPE methods, new spiritually oriented methods, were found in this study. These were: Spiritual Connection with Self, Spiritual Sanctification of Nature, Positive Solitude, Altruism, Search for Meaning, Visualization, Healing Therapy, Spiritual Music and Meditation.

As Table 6 shows, all SCOPE methods are used by the age group 41-64 years. This age group is also the only group with members who used Altruism. The methods used by all age groups are: Nature, Positive Solitude, Search for Meaning, Healing therapy, Meditation and Spiritual Music. Naturally, what is presented above as age differences concerning the different religious and spiritually oriented coping methods is only a preliminary outline of which methods are used by different age groups. It does not tell us how use of the same method by two or all age groups might differ. Accord-

ingly, I can only relate some impressions I got from the differences observed.

Analysis

My first impression regarding the age group 65+ is that members of this group, in comparison with the other age groups, have been more unambiguous in what they stand for regarding their philosophy of life and have had a clear understanding of which coping methods may be more helpful for them. They have also been more selective. This may be because, given their longer lives in comparison to the other age groups, they had previously faced other difficulties and had experience with coping they could apply to their coping with cancer.

My second impression regarding this group is that the use of religious coping methods was more frequent among age group 65+ than among other age groups. My explanation is that the members of this group, 65+, have been subject to some religious socialization in their childhood and that there is a good chance they had a religious upbringing. Even at school they were subject to some degree of Christian indoctrination. Because secularism had not yet fully taken hold when their primary socialization took place, they may also have had religious influences from other sources in society.

The table presented above tells us that the informants in age group 41-64 have used almost all methods found in this study. My impression concerning this age group is that the tendency toward spirituality is stronger among them than among the others. This may be partly due to the fact that the majority of informants in this study belonged to this group, which increases the chance of finding different coping methods among this age group than are found among the other age groups. Another possibility is that informants in the age group 41-64 belong to a generation in Sweden that was socialized to be optimistic, self-reliant and pragmatic. Therefore, they may have had a sufficiently strong inclination to use every possible means (both traditional religious methods and spiritually oriented ones) of dealing with their illness. We may also presume that the members of this age group have access both to religious and to non-religious spiritual resources. This is because, during their childhood, the process of secularization had not yet reached its climax and therefore they still had an opportunity to receive religious education at home and in school. They may even have attended voluntary Bible classes, so-called Sunday School, which sometimes functioned like kindergarten too, such that even non-religious families let their children spend some hours in these schools in order to be together with other children, especially if both parents worked on Sundays. During their youth, this age group lived in an era of decline in early religious socialization and in church-related religiousness. They had, therefore, an opportunity to internalize the norms and values of a secular society. Now, they are growing older in a time when religion is

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returning to social and political life, and when new forms of religiosity and spirituality are growing. As we saw in Chapter 4, a kind of private religiosity and non-religious spirituality has taken the place of religion. The prevalence of a tendency toward "private religiousness" and spirituality among Swedes has been, as mentioned before, confirmed by several studies (*Uppsala Study* and EVS). Regarding the different periods through which the age group 41-64 has lived, we may assume that the members of this age group, when facing a difficult situation that requires one to deal with existential questions, were able to turn to religious coping methods as well as to non-religious spiritually oriented coping methods, such as the SCOPE methods.

Regarding the age group 18-40, I see a limited use of religious coping among this age group. My explanation is that, in Sweden, members of this age group, as opposed to members of the other age groups, have been socialized in a society where religion has been neither an integrated part of everyday life nor had any considerable status in the social and political structure of society. It may also be cautiously maintained that the parents of the members of this group generally brought their children up with secular rather than religious values. Because for the past decades the Swedish school system has been completely secularized and religious education has been strictly a matter of information, we may suppose that the acquaintance of the age group 18-40 with religion is mainly informational as opposed to religious in nature. Although socialized in a time when secularism had reached its climax, the members of the age group 18-40 now live in a post-modern era when new forms of spiritually oriented religiosity and spirituality are growing. So when facing a serious difficulty in life, which places the existential questions in the foreground, it is understandable that members of this age group do not tend to turn to religiosity. They use non-religious spiritually oriented coping methods instead of conventional forms of religious coping.

The above-mentioned explanations lead me to the assumption that one factor that probably affects the use of religious and spiritually oriented coping methods among informants is primary religious socialization. Analysis of the data from a survey conducted in 1990 in all of the Scandinavian countries indicates that "the primary religious socialization seems to form one important pre-condition for a later deepening of a religious identity and a closer association with a religious community" (Riis 1994). As mentioned before, one reason people turn to religion in a time of crisis is that religion is more accessible in their socio-cultural context than are other resources; in other words, religion is more available to the individual when it is a larger part of her/his orienting system (Pargament 1997:144). Such being the case, we can imagine that for people who have experienced primary religious socialization, for instance those in the 65+ age group, it is easier to turn to religion in the event of a serious difficulty in life. They simply have greater access to religious coping methods than do those who have not internalized religious norms and values during their primary socialization process. On the

other hand, people who have not gone through religious socialization in their childhood, such as those in the age group 18-40, have poor access in their orienting system to religion in times of crisis. Although people like those in age group 18-40 do not have rich religious resources to use in times of crisis, if they live in a society in which other transcendence resources are flourishing, e.g., private religion, they do have, as we saw in the case of the Swedish cancer patients, an opportunity to use non-religious spiritual resources as well.

Summing up this section, on the basis of the present results on age differences, we may cautiously hypothesize that, in addition to other factors such as culture and ways of thinking, primary religious socialization may play an important role in the use of religious and spiritually oriented coping methods.

Gender Differences in Coping

Review of Studies on Gender, Religiosity, Spirituality and Coping

In this chapter, I wish to outline the differences found between men and women in their use of religious and spiritually oriented coping methods, but first I will provide a review of previous studies in the field of religious and spiritually oriented coping that have looked at gender. Research on the gender aspects of religious and spiritually oriented coping is scarce. There is, however, an assumption that women use religious and spiritually oriented coping methods more than men do. This assumption is based on studies in which the focus has been on women and possibly on a gender difference in coping.

Some researchers believe that women express and perhaps experience spirituality differently than men do (Belenky et al. 1986; Ochs 1996; Ruffin-grahal & Anderson 1994). Although scholars, particularly those who advocate life span theories, have assumed that adult developmental research conducted on males may be generalized to women (Fowler 1991), research on women's developmental experiences has shown that male models differ from female models (Dobbie 1991; Miller 1986).

One of the issues connected to spiritual development and experiences is that of health or illness concerns (Vogel 1995). Some examples will be presented below. Studies (Johnson & Spilka 1991; Gall et al. 2000) conducted among women with breast cancer show that these women referred to their relationship with God and their need for closeness to God. They reported that this closeness helped "them feel less alone and gives them courage in dealing with their illness" (Gall et al. 2000:24).

In one study, a self-administered questionnaire was completed by 108 women with various stages of cancer and 39 women with benign gynecologic disease (Roberts et al. 1997). This study was undertaken to assess the life views, practices, values and aspirations of women with various stages of gynecologic cancer. The study shows that women with gynecologic cancer depend on their religious convictions and experiences in coping with the disease.

In a study (Risberg et al. 1996) on spiritual healing among 911 Norwegian hospitalized cancer patients (642 of whom – 70.5%- were included in the analysis), the use of "alternative medicine'", here called non-proven therapy (NPT), was examined. This study was a questionnaire-based multicenter study. Spiritual healing, defined as faith healing and healing by laying on of hands, was the most frequently used NPT among Norwegian cancer patients. As the findings of this survey show, elderly women patients using faith healing were more likely to describe themselves as religious. One hundred and

thirty-nine (23%) of the responding patients reported a strengthening of their religious belief after the diagnosis of cancer.

In a study exploring the relationship between spiritual well-being and quality of life (QOL) in gynecologic oncology patients, eighteen women with gynecologic cancer completed a self-administrated questionnaire requesting socio-demographic, medical, spiritual and functional information. The findings indicated a positive relationship between spirituality and QOL. Patients with gynecologic cancers other than ovarian reported a better QOL and a higher degree of spiritual, existential and religious well-being (Gioiella et al. 1998).

The literature on spirituality and illness with a focus on both age and gender is not vast. Until recently, research in this area was initiated from the male perspective. There are, however, a few studies aimed at understanding how older women develop and make sense of life and death (e.g., Foley et al. 1998) – especially when they suffer from a serious illness (e.g., Ruffingrahal & Anderson 1994; Wyatt et al. 1999).

Ruffingrahal and Anderson (1994) conducted a study based on secondary analysis of data from an investigation including 161 community-dwelling older women, aged 65 to 99. These data had been obtained through structured personal interviews including "The Integration Inventory (II)". Findings highlight the interplay of personal and ecological factors, among others, religiosity, and their importance to older women's everyday experience of well-being.

In another study (Feher & Maly 1999) aimed at identifying and examining religious and spiritually oriented coping strategies among elderly women with newly diagnosed breast cancer, a sample of 33 women 65 years of age was recruited within 6 months of diagnosis. Respondents participated in a structured interview with open-ended questions. Participants' religious backgrounds were varied. As the findings of the study indicate, religious and/or spiritual belief either increased or stayed the same during the time of health crisis. The researchers conclude that religious and spiritual faith provide elderly women with newly diagnosed breast cancer with important tools for coping with their illness and that the use of religious and spiritually oriented coping methods should be recognized by diagnosing physicians.

Another study (Wyatt et al. 1999) conducted on 699 older cancer patients, 64 years of age or older, shows that approximately 33% of these patients used complementary therapies, among others religious and spiritually oriented coping strategies. Individuals using such therapies were more likely to be women and to be breast cancer patients. There were significant differences between users and nonusers in type of physical symptom experiences, but no differences in reported depressive symptomatology or spirituality.

As it seems, religious and spiritual resources have been an effective factor for women coping with their illness. There are, however, studies that do not support this assumption. For instance, Rifkin et al. (1999) tested the hy-

pothesis that religious variables, such as a person's belief that her/his illness was God's will, would predict psychosocial adjustment in 50 patients, most of whom were Catholic Hispanic women attending a medical oncology clinic (42 women, 8 men). By using the Psychosocial Adjustment to Illness Scale as the outcome measure, the authors found few associations with religious variables, but many with clinical variables.

The studies presented above were mainly conducted in cultural contexts, such as the American one, in which religion plays an important role in society and in which organizational ways of practicing religion predominate. This is not the case in all societies. As mentioned before, in Sweden, only 15% of Swedes believe in a personal God, and people are more spiritually oriented than religiously oriented. Concerning cultural contexts like the Swedish one, two important questions should then be answered regarding the issue of a gender perspective and religious and spiritually oriented coping:

1. Is there any difference between the religious and spiritually oriented coping methods used by men and women?
2. Are the above-mentioned assumptions on the frequency and effectiveness of religious and spiritually oriented coping methods among women in a cultural context like the Swedish one valid?

As it is qualitative in nature, the present research cannot answer these questions from the perspective of an extensive exploration of religious and spiritually oriented coping as a function of gender. It can, however, help us to begin to understand which differences may exist between women and men in their use of religious and spiritually oriented coping methods. In the following, I will present the results obtained in this study concerning possible gender differences in use of religious and spiritually oriented coping methods.

Results Concerning Gender Differences

RCOPE methods: Concerning RCOPE methods, no difference is found between men and women (see Table 7). All methods and the different patterns recognized in each method were used by both sexes.

SRCOPE methods: The differences found between men and women in their use of these methods are shown in Table 7. As may be seen, women have used all of the SRCOPE methods, while men have used only Collaborative Spiritual Coping, Spiritual Discontent and Spiritual Prayer.

SCOPE methods: Table 7 shows the differences between men and women in their use of the different SCOPE methods. As we see, women have used all of the SCOPE methods, but men have not used Spiritual Connection with Self, SCOPE-Altruism and Healing Therapy.

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Table 7. Gender differences

Men	Women
RCOPE	
Religious Focus	Religious Focus
Spiritual Connection	Spiritual Connection
Pleading for Direct Intercession	Pleading for Direct Intercession
Self-Directing Religious Coping	Self-Directing Religious Coping
Seeking Spiritual Support	Seeking Spiritual Support
Spiritual Discontent	Spiritual Discontent
Collaborative Religious Coping	Collaborative Religious Coping
Benevolent Religious Reappraisal	Benevolent Religious Reappraisal
Sanctification of Nature	Sanctification of Nature
SRCOPE	
Collaborative Spiritual Coping	Collaborative Spiritual Coping
Spiritual Discontent	Spiritual Discontent
Spiritual Prayer	Spiritual Prayer
----	Punishment
----	Benevolent Spiritual Reappraisal
----	Self-Directing Coping
----	Spiritual Support
SCOPE	
-----	Spiritual Connection with Self
Spiritual Sanctification of Nature	Spiritual Sanctification of Nature
Positive Solitude	Positive Solitude
Search for Meaning	Search for Meaning
Visualization	Visualization
-----	Healing Therapy
Spiritual Music	Spiritual Music
Meditation	Meditation
----	Altruism

Analysis

In one study conducted among people in different Scandinavian countries, Riis (1994) looked at their philosophy of life as well as their view of religion and religious values. This study focused on, among other things, differences between age groups and between men and women. As this study shows, in Scandinavian countries,

> Whereas age is generally important for analysis of religiousness, gender is relevant for some types of religious attitudes. It seems especially important for analysis of personal, religious views, such as those expressed as general religiosity or the attitudes to atheism. Gender is less important for analysing institutional religiosity, such as the authority ascribed to the church (Riis 1994:122).

According to Riis (1994), the gender differences are considerable when non-institutional forms of religiosity or non-orthodox beliefs are considered. She shows that women believe more often than men in a spiritual force and that the gender difference is especially striking when it regards belief in re-incarnation. She adds that:

> It is especially strong among young and middle aged women, though not nearly as widespread among young men. This seems to indicate that women tend to be more open to religious and spiritual views than men (Riis 1994:125).

Riis' assumption is confirmed by another study. On the basis of data obtained from the European Value Study (EVS 1990), gender differences concerning religious belief in different Scandinavian countries have been studied. This study shows (Sundback 1994:142) that Swedes and Finns, more than people in other Scandinavian countries, tend to see God as an abstract spirit or power. "The tendency is especially stressed by the Swedish women" (ibid.) According to this study, Swedish women are "less religious, when this concept is given a traditional content. On the other hand, Swedish women express a strong tendency for a diffuse and private religious feeling" (Sundback 1994:145).

Given that this is a qualitative study, I can hardly maintain, based on the present result on gender differences in religious and spiritually oriented coping, that my study confirms the results of the above studies concerning women's stronger tendency toward spirituality as compared with men. However, I can assert that a tendency toward spirituality was quite obvious among my female informants. As we see in Table 7, women have used all the spiritually oriented coping methods, but the men have not. This may partly be due to the fact that there were more women than men in my study. We cannot exclude, however, the possibility that the use of all spiritual methods in the female group may result from the strong tendency toward spirituality among Swedish women, especially in the young and middle-aged generations, as other studies have shown.

One interesting point is that SCOPE-Empathy/Altruism is only found among women in the age group 40-64 years. As explained in Chapter 7, and in accordance with Damasio's (2000) view of the existence of a link between emotions and behavioral decisions, I regard, as do other researchers (e.g., Costello 2001), empathy and altruism as inseparable from each other. However, regarding empathy and altruism as inseparable may contribute to an unclear picture of sex differences (ibid). Some studies witness this. For instance, while one study on gender differences in altruism in 573 pairs of twins shows that females are significantly more altruistic than males (Rushton 1989), another study conducted by Dougherty (1983) shows that subjects of both genders were more likely to help people who were acting in "appro-

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priate sex roles". A study (Androni & Vesterlund 2001) conducted at the University of Wisconsin and Iowa State University provides a potential for explaining and unifying the varying results from different studies. This study shows that

> depending on the price of giving, either sex can be found to be more altruistic. When the price of giving is low, men appear more altruistic, and when the price is high, women are more generous. Stated differently, men are more likely to be either perfectly selfish or perfectly selfless, whereas women care more about equalizing payoffs. This leads to demand curves for altruism that cross and those for men are more price-elastic (ibid:306).

My impression from the result of my interviews is that we can talk of gender differences with regard to altruism. Regarding the role of price in altruistic behavior, because none of the men used empathy/altruism as a coping method, it is not possible on the basis of my study to falsify or verify the above-mentioned finding on the role of price in gender differences in altruism.

Besides a gender difference, my study also shows an age difference in use of SCOPE-Empathy/altruism. Use of this coping method was found only among females in the age group 41-64 years. My hypothesis is that this age effect is dependent on the fact that this age group was socialized in a period when the Nordic Welfare Model[1] – the so-called institutional welfare state – was at its peak. Solidarity, gender equality and equalization of incomes were among the aims this model advocated. Those who were socialized during this period have presumably internalized the norms and values that promoted these aims. These norms and values, in turn, have paved the way for strong feelings of empathy/altruism in the ways of thinking of this age group.

Summing up this chapter, I have presented and analyzed the results obtained in my study concerning the age and gender differences in the use of RCOPE, SRCOPE and SCOPE. I can support the notion that, in the Scandinavian context, whereas "age is generally important for analysis of religiousness, gender is relevant for some types of religious attitudes" (Riis 1994:122). The most important gender difference found here is that female informants used all of the spiritually oriented coping methods, while the men did not. In other words, female informants have shown a greater tendency toward spirituality than have male informants. The age difference, however, was more noticeable than the gender difference. As mentioned before, one factor affecting the use of religious and spiritually oriented coping methods is probably the primary religious socialization. My hypothesis is that different generations in Sweden have experienced very different primary religious socializations, but that this does not apply to the two sexes. In other words, the possible differ-

ence in the primary religious socialization that men and women have experienced in every age group is not as great as that between different age groups.

Note:

[1] "The Nordic welfare model is characterized by a relatively high level of public services (which are financed through direct taxation), a relatively generous benefit scheme based on universal systems, and - when it comes to financing - a relatively high level of taxation. Key aspects of this model have been designated as successful in various comparative international studies: the Nordic countries are quite prosperous, employment levels among both men and women are high and the effort to achieve equalization of incomes has come fairly far. As regards gender equality, in the contexts in which it is usually measured, the Nordic countries have been front-runners for several decades, and are often ranked at or near the top of the list of international comparative studies. The same is the case for other social indicators, such as child mortality, average life expectancy, balanced regional distribution and popular political participation" (See http://program.forskningsradet.no/nmr/programplan_eng.html).

Chapter 9: Discussion and Summary

Religious and Spiritually Oriented Coping

The study on the basis of which this book is written has as it aims:

1. to examine whether becoming ill has changed the religiousness of cancer patients in this study;
2. to discover which religious and spiritually oriented coping methods – RCOPE methods as well as "new" religious and spiritually oriented coping methods consisting of SRCOPE and SCOPE – are used by the 51 cancer patients in this study;
3. to study what the role of culture has been in the choice of religious and spiritually oriented coping methods.

Regarding **the first aim**, proceeding from the relevant results, we can hardly maintain that the cancer patients in this study have turned to religion in coping, although some coping methods are recognized as religious.

One important question addressed by researchers who deal with religious coping is whether people facing difficult circumstances make more use of religion than of other ways of coping? Pargament's (1997:135) consideration that "Perhaps those who involve religion in more difficult times involve religion in the daily frustrations of living as well" sheds light on one important factor, i.e. that people's life backgrounds must be taken into consideration when answering the above question. One of the most essential components of an individual's background is the cultural framework in which she/he has been socialized. Much of the research showing that a high percentage of people "turn to religion in coping" has been conducted in the US, where religion is an integrated part of people's lives. The situation is different in Sweden. The present results may be better understood if we recall that one determining factor causing people to use religion in coping is, as Pargament (1997:147) points out:

> The relative availability of religion is shaped by personal, situational, and social factors. To the extent that religion becomes a larger and more integrated part of the orienting system, it takes on a greater role in coping. To the extent that religion becomes less prominent in the orienting system, more disconnected from other resources, and less to the range of life experiences, it recedes in importance in coping.

Considering the very secular nature of Swedish society – where religion does not play a decisive role in the everyday life of individuals and where, even for believers, faith is not the only element of their orienting systems, but one among others – we can understand why, for the cancer patients in this study, religion was less involved in coping. It would seem that, in Sweden, there are more available non-religious resources than religious resources. This does not mean, however, that people never turn to religion in coping, but that people have a tendency to seek spiritually oriented coping methods rather than religious ones.

With respect to the **second aim**, some of the observed religious coping methods are connected to the key functions meaning, control and comfort, i.e. the Religious Methods of Coping to Find Meaning, the Religious Methods of Coping to Gain Control and the Religious Methods of Coping to Gain Comfort and Closeness to God. However, the methods related to the key functions intimacy and life transformation were not used by the informants.

The following RCOPE-methods were found in this study: Benevolent Religious Reappraisal, Collaborative Religious Coping, Pleading for Direct Intercession, Self-Directing Religious Coping, Seeking Spiritual Support, Religious Focus, Spiritual Connection, Spiritual Discontent. Also identified is a method called Sanctification of Nature, which does not appear on the RCOPE list, but which, in my view, may be categorized as a religious coping method belonging to the group *Religious Methods of Coping to Gain Comfort and Closeness to God.*

In addition to RCOPE methods, some methods were reported that cannot be categorized as RCOPE, but that have some similarities with some of the RCOPE methods. These are SRCOPE-Punishment, SRCOPE-Benevolent Spiritual Reappraisal, SRCOPE-Collaborative Spiritual Coping, SRCOPE-Spiritual Discontent, SCOPE-Spiritual Prayer, SCOPE-Self-Directing Coping and SCOPE-Spiritual Support.

Other identified spiritual methods are not related to the RCOPE methods. These are Spiritual Connection with Oneself, Spiritual Sanctification of Nature, Positive Solitude, Empathy/Altruism, Searching for Meaning, Visualization, Healing Therapy, Spiritual Music and Meditation.

This study helps us to identify among the informants some tendencies that have presumably influenced their choice of religious and spiritually oriented coping methods. These tendencies are:

- A tendency toward gaining control by the means of, among other things, religious methods. In this respect, seeking God's or a spiritual being's help seems to be primarily a means of gaining more power so that the patients can deal, by themselves, with the stressors caused by cancer. In this respect, an apparent tendency toward relying on oneself when facing difficulties was recognized.

- A tendency toward seeking spiritual closeness with God or a supreme value. The informants seem more likely to focus on the subjective connotation of religion – thinking about spiritual matters and spiritual connection – than to engage in religious rituals and activities.
- A tendency toward seeking privacy and disengaging from other people when facing the stressors of the illness.
- A tendency toward natural romanticism, which makes nature an available source for coping.
- A tendency toward rationalism and pragmatism colored by optimism when facing the problems brought about by the illness.

One factor that may explain the above-mentioned tendencies is the impact of the culture and ways of thinking on how individuals deal with their problems. In the following, proceeding from a cultural perspective, I will discuss the results obtained in this study. Here the **third aim** is in focus.

Tendency toward control and self-direction: Having been socialized in a secular and individual-directed society, such as the Swedish one, has presumably reinforced Swedes' tendency to solve their personal problems by relying primarily on themselves and not on a supreme power. This is even clearer if we consider that, as pointed out in Chapter 4, Sweden stands out as one of the most secularized countries in the world and has a strong inclination toward individualism (Pettersson & Riis 1994).

The informants' strong tendency toward using the Self-directed Coping Methods is, hence, understandable if we take into consideration the combination of strong individualism, secularism and privatization of religion found in Sweden.

Tendency toward spirituality: As we mentioned in Chapter 4, Swedish society has moved, during the past three centuries, toward a more individualistic and secular society, where religion has become less organized and more private. This in turn, together with other characteristics of the Swedish culture, such as nature romanticism, has probably given rise to the predominance of spirituality as opposed to religiosity among Swedes.

With regard to the fact that Swedes are more likely to describe their religious lives in spiritual terms (Jeffner 1988; Wikström 1998), it seems appropriate to talk about the existence of a kind of spirituality rather than religiosity among Swedes. Concerning this point, we can understand why, for the informants in this study, thinking about spiritual matters and spiritual connection was found to be more important than religious activities and rituals.

Tendency toward privacy: A tendency toward privacy and refusing to involve other people when coping with a problem is revealed in the infor-

mants' unwillingness to use Religious Methods of Coping to Gain Intimacy with Others. To understand this tendency, we should take into consideration that Swedes are very individual-oriented and seek positive solitude. This is not to say that there not are some, especially old persons, who suffer from loneliness. With regard to the notion that Swedes are individual-oriented, we find the following about them in a handbook[1] for newcomers to Sweden:

> As long as it is not permanent or forced upon them, most Swedes not only tolerate but even enjoy being by themselves. Swedes take it for granted that other people share their preference for privacy, and they try to respect this. They don't thrust themselves on others. They don't ask personal questions… The ideal is to live in peace and to be left in peace.

This partially explains the tendency toward privacy in coping found among Swedes and the fact that they generally do not wish to bother others with their problems.

Tendency towards natural romanticism: It is said that "Swedes generally speaking have an almost sacred relationship to nature" (Herlitz 1995:36). As discussed before, in the era of postmaterialism, we are witnessing an increased tendency toward "private religion" and spirituality among modern peoples, especially Swedes. As more of the sacred becomes private, the role of music, literature, psychoanalysis and nature in mediating existential and "religious" experiences becomes more important. In this regard, for Swedes, nature has a special position. It seems as though modern Swedes are seeking experiences that used to be mediated by Christian culture, but now in ways other than through traditional religion. One of these ways involves experiencing one's unity with nature. Being in natural environments and feeling a sense of unity with them can give spiritual feelings of unification with the whole of existence. As some informants stressed, nature becomes the church and unity with the holy becomes unity with nature.

Such a view of nature signifies a culture in which natural romanticism has been historically strong. The Swedish people generally view themselves as a nature-loving nation (Uddenberg 1995:37), and for about a century, the national feelings of Swedish people have been constructed on the basis of, among other things, a profound love of nature. There are plenty of books and articles (see, e.g., Sundin 1981; Johanisson 1984) discussing the strong relation between nationalism and the interest in and love of nature in Sweden. Regarding the above, it is not difficult to understand why many Swedes believe that their well-being depends on having contact with nature (Uddenberg 19995:39) and why such contact is one of the most essential coping methods used by cancer patients in this study.

Tendency toward rationalism and pragmatism: Last but not least is the strong tendency toward rationalism and pragmatism in Swedish ways of thinking – a tendency that has probably influenced how the Swedish patients in this study coped with their illness. Rationalism and pragmatism are regarded as two important components of Swedish ways of thinking (Pettersson & Riis 1994). Swedes are famous for their pragmatism. As Runblom (1998) emphasizes, the Swedish tradition offers a high degree of pragmatism when it comes to solving societal problems. The Swedish model of corporatist policy, which has received international attention, has been referred to as "principled pragmatism" (Heclo & Madsen 1987). As mentioned before, religious coping methods such as Punishing God Reappraisal, Demonic Reappraisal and Reappraisal of God's Powers – three ways of coping to find meaning – were not prevalent among the informants. Use of these methods requires that the individual be a fatalist and believe in a God or Devil who controls individuals' lives, deeds and destinies. Being socialized in a culture with a strong tendency toward rationalism and pragmatism may make it difficult to use coping methods that are neither rational nor beneficial and that demand fatalism.

Age and Gender

In conclusion, although looking at the role of age and gender was not the aim of this study, I wish to point out the role of these factors in the choice of religious and spiritually oriented coping methods. In this regard, we may cautiously assume, on the basis of the results obtained in this study, that primary religious socialization, in addition to culture and ways of thinking, impacts the use of religious and spiritually oriented coping methods. On other words, those who have gone through *primary religious socialization* have greater access to religious coping methods than do those who have not internalized the religious norms and values in their primary socialization process. As it seems, a clear gender difference is not found in this respect. The study does show, however, that women have used more of the spiritually oriented coping methods than men have. The results indicate that, as a group, women in the age group 40-64 used all methods found in this study.

Summary

I wish to stress that this study has shown the importance of considering culture and ways of thinking when investigating different religious coping methods. In this connection, the study has revealed the impact of rationalism, individualism, secularism, natural romanticism and a tendency toward spirituality rather than religiosity in Swedish ways of thinking on the choice of coping methods among informants.

Concerning the use of religious and spiritually oriented methods by the Swedish informants, we learn from this study that:

- Gaining control over the situation is a very important coping strategy among Swedish informants.
- The informants show a strong tendency toward relying primarily on themselves for solving problems related to their disease. Receiving help from other sources, among others God or a supreme power, seems to primarily be a way to gain more power to help oneself, as opposed to passively waiting for a miracle.
- For the informants, thinking about spiritual matters and spiritual connection seems to be more important than participating in religious rituals and activities.
- Turning to nature as a sacred and available resource is a coping method that all informants have used, regardless of their outlook on God, their religion and philosophy of life or their age and gender.
- Middle-age women seem to have better access to both religious and spiritual resources in their orienting systems than do other groups. Moreover, they showed a greater tendency toward spirituality than did the other informants.

Further Remarks

Coping with a life crisis and seeking significance in a stressful situation is a complicated process. The individual must wrestle with different forces, sometimes forces that oppose each other. Some forces can be controlled, some cannot; some are intellectually manageable, some are not. Some should be faced using emotional resources, some should not. Some forces can be controlled by the individual, some with the help of others. Some require immediate intervention, some need time to manage. This being the case, an individual who faces a major life crisis needs different resources for coping with her/his problems. What is required, therefore, is collaboration from as many professionals, organizations and even people around the individual as possible, who can help her/him through the coping process by providing different coping resources. As my study shows, spirituality is one such coping resource. Unfortunately, this issue has hardly been taken into consideration by the physicians, psychologists and caregivers who work with cancer patients in Sweden and, as it seems, also in other countries where religion is not an integrated part of most individuals' lives. The results obtained in this study concerning spiritually oriented coping among cancer patients in Sweden, although they cannot be generalized, call for greater sensitivity to and integration of religion and spirituality into the assessment and counseling of cancer patients. To do this, however, we need more qualitative and quantitative research in the field of spirituality and health. Not only it is necessary to examine, in the framework of a survey investigation,

the extent to which the spiritually oriented coping strategies found in this study are prevalent among cancer patients in Sweden and other countries where spirituality is more dominant than religiosity, but also to investigate, from a cultural perspective, religious and spiritually oriented coping among religious groups other than Christians.

As mentioned, one issue that should be taken into consideration when dealing with people coping with cancer is their search for significance. In doing this, we need the development and evaluation of what Pargament (1997:404) called "psychospiritual interventions", which can be used in individuals as well as groups coping with major life crises. This doesn't mean that psychologists and other health professionals should turn to our modern priests or that more churches and chapels should be established in hospitals and health centers. What is at issue here is being more open minded in our professional understanding of cancer patients' divergent psychological needs, among other things their need to search for significance and their effort to connect to a greater whole. We must help them professionally in this journey.

Note:

[1] htt://www.newcomers.se/living_sweden/swedishness.htm

References

Acklin, M. W., Brown, E. C. & Mauger, P. A. 1983. The role of religious of values in coping with cancer. **Journal of Religion and Health,** 22:322-333.

Ahmadi Lewin F. 2001b. Gerotranscendence and different cultural settings. **Ageing and Society**, 21(4):395-415.

Ahmadi Lewin, F. & Thomas, L. E. 2000. Gerotranscendence and life satisfaction: Studies of religious and secular Iranians and Turks. **Journal of Religious Gerontology,** 12(1):17-41.

Ahmadi Lewin, F. 2001a. Investigating the religious and spiritually-oriented coping Strategies in the Swedish context: A review of literature and directions for future research. **Illness, Crisis & Loss,** 9(4):336-356.

Ahmadi, F. 1998. Sufism and gerotranscendence. The impact of way of thinking, culture and aging on spiritual maturity. **Journal of Aging and Identity**, 3(4):189-211.

Ahmadi, F. 2000a. Reflections on spiritual maturity and gerotranscendence: Dialogues with two sufis. **Journal of Religious Gerontology,** 11(29):137-149.

Ahmadi, F. 2000b. Development towards wisdom and maturity: Sufi conception of self. **Journal of Aging and Identity,** 5(3):137-149.

Ahmadi, N. & Ahmadi, F. 1998. **Iranian Islam: The Concept of the Individual.** London: MacMillan Press.

Aldridge, D. 2000. **Spirituality, Healing and Medicine**. London: Jessica Kingsley Publishers.

Aldwin, C. M. 2000. **Stress, Coping and Development**. New York: Guilford Press.

Allport, G. & Ross, J. M. 1967. Personal religious orientation and prejudice**. Journal of Personality and Social Psychology**, 5:423-443.

Allport, G. 1966. The religious context of prejudice. **Journal of Personality and Social Psychology,** 5:432-443.

Alma, H. A. 19988. **Identiteit door Verbondenheid: Eden Godsdienstpsychologisch Onderzoek naar Identificatie en Christelijk Geloof** (Identity through alliance. A study in the psychology of religion on identification and Christian faith). Kampen: Kok.

Alma, H., Pieper, J. & Uden, M. Van. 2003. When I find myself in times of trouble...: Pargament's religious coping scales in the Netherlands. In N.G. Holm (ed.), **Archive für Religions Psychologie** (Archive for the Psychology of Religio), 24:64-74. Göttingen: Vandenhoeck & Ruprecht.

Andreoni, J. & Vesterlund L. 2001. Which is the fair sex? Gender differences in Altruism. **The Quarterly Journal of Economics**, February:293-312.

Argyle, M. & Beit-Hallahmi. B. 1975. **The Social Psychology of Religion**. London: Routledge & Kegan Paul.

Atchley, R. C. 1997. The subjective importance of being religious and its effect on health and moral 14 years later. **Journal of Aging Studies**, 11(2):131-141.

Baider, L. & Sarell, M. 1983. Perceptions and causal attributions of Israeli women with breast cancer concerning Their illness: the effects of ethnicity and religiosity. **Psychother Psychosom**, 39:136-143.

Barinaga, E. 1999. **Swedishness Through L*agom*. Can Words Tell Us Anything About a Culture?** Research paper series 6: Centre for Advanced Studies in Leadership.

Barnes, V. A., Treiber, F. A. & Davis, H. 2001. Impact of transcendental meditation1 on cardiovascular function at rest and during acute stress in adolescents with high normal blood pressure. **Journal of Psychosomatic Research**, 51(4):597-605.

Baston, C. D., Schoenrade P. & Ventis W. l. 1993. **Religion and the Individual. A Social- Psychological Perspective.** New York: Oxford University Press.

Battail, J. F. & Battail, M. 2004. **Scandinavia**. USA: Vilo International.

Becker, J. 1998. Readers write: My chair. **The Sun**, 33-34.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R. & Traule, J. M. 1986. **Women's Ways of Knowing: The Development of Self, Voice, and Mind**. New York: Basic Books.

Benner, D. G. 1989. Toward a psychology of spirituality: Implications for personality and psychotherapy. **Journal of Psychology and Christianity**, 8:19-30.

Berger, P. L. 1974. Some second thoughts on substantive versus functional definitions of religion. **Journal for the Scientific Study of Religion,** 13:125-134.

Bibby, R. W. 1983. Searching for invisible thread: Meaning systems in contemporary Canada. **Journal for the Scientific Study of Religion,** 22(2):101-119.

Bickel, C. O., Ciarrocchi, J. W., Sheers, J. J., Estadt, B. K., Powell D. A. &Pargament, K. L. 1998. Perceived stress, religious coping styles and depressive affect. **Journal of Psychology and Christianity,** 17(1):33-42.

Bijur, P. E., Wallston, K. A., Smith, C.A., Lifrak, S. & Friedman, S. B. 1993. **Gender Differences in Turning to Religion for Coping**. Paper presented at the meeting of the American Psychological Association, Toronto.

Billings A. G, Moos R. H. 1981. The role of coping response in attenuating the impact of stressful life events. **Journal of Behavioural Medicine,** 4:157-189.

Boik, J. 2001. **Natural Compounds in Cancer Therapy**. *Oregon:* Oregon Medical Press.

Bourdreaux, E., Catz, S., Ryan, L., Amaral-Melendez, M. & Brantley, P.J. 1995. The ways of religious coping scale: Reliability, validity, and scale development. **Assessment**, 2:233-244.

Buber, M. 1970. **I and Thou**. New York: Charles Scribner's Sons.

Burkhardt M. A. 1993. Characteristics of spirituality in the lives of women in rural appalachina community. **Journal of Transcultural Nursing**, 4:212-218.

Burkhardt, M. A. 1994. Becoming and connecting elements of spirituality for women. **Holistic Nursing Practice**, 8(4):12-21.

Burns, D. S. 2001. The effect of the bonny method of guided imagery and music on the mood and life quality of cancer patients. **Journal of Music Therapy,** 38(51-65).

Carey, R. G. 1974. Living until death. **Hospital Progress**, 55(2):82-87.

Carlson, C. R., Bacaseta, P. E. & Simanton, D. A. 1988. A controlled evaluation of devotional meditation and progressive relaxation. **Journal of Psychology and Theology**, 16(4):362-368.

Cassileth, B. R., Vickers, A. J. & Magill, L. A. 2003. Music therapy for mood disturbance during hospitalization for autologous stem cell transplantation: A randomized controlled trial. **Cancer**, 98(I12):2723-2729.

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Caudill, W. 1958. **Effects of Social and Cultural Systems in Reactions to Stress**. New York: social Science Research Council.

Cella, D. F. & Tross, S. 1986. Psychological adjustment to survival form Hodgkins' disease. **Journal of consulting & Clinical Psychology**, 54:616-622.

Coe, G. A. 1916. **The Psychology of Religion**. Chicago: University of Chicago Press.

Cohen, S. & Wills, T. A. 1985. Stress, social support, and the bufferin hypothesis. **Psychological Bulletin**, 98:310-357.

Coker, K. H. 1999. Meditation and prostate cancer: integrating a mind/body intervention with traditional therapies. **Seminars in Urologic Oncology,**17:111-118.

Coleman, P. 1992. Questioning of religious meanings in later life. **Newsletter**, 42:23-26. Psychologist Special interest Group in the Elderly (British Psychological Society).

Coleman, P. 2000. **Stability and Change in Religious Attitudes with Ageing in a 20 Year Longitudinal Study**. Paper presented at the British Society of Gerontology Conference in Oxford in September 2000.

Conway, K. 1985-1986. Coping with the stress of medical problems among black and white elderly. **International Journal of Aging and Human Development**, 21:39-48.

Cooper, P. 1999. **Secrets of Creative Visualization**. York Beach: wieserbook.

Costello, B. 2001. Altruism: Selfless or selfish. Article on line. **Serendip**. Second Web Report. Bilology 202. Retrieved from: http://serendip.brynmawr.edu/bb/neuro/neuro01/web2/Costello.html.

Cotton, S. P., Levin, E. G., Fitzpatrick, C. M. & Dold, K. H. 1998**. Spirituality, Quality of Life and Psychological Adjustment in Women and Breast Cancer**. Paper presented at the Annual Meeting of the American Psychological Association. San Francisco.

Cox, T. 1980. **Stress**. Baltimore: University Park press.

Dabrowski, K. 1964. **Positive Disintegration**. Boston: Little Brown & Co.

Damasio, A. 2000. **The Feeling of Things: Body and Emotion in the Making of Consciousness**. New York: Harvest.

Dein, S. 1997. Does being religious help or hinder coping with chronic illness? A critical literature review. **Palliative Medicine,** 11:291-298.

Derogatis, L. R., Morrow, G. R., Fetting, J., Penman, D., Piasetski, S., Schmale, A. M., Henrichs, M. & Carnicke, C. L. M. 1983. The prevalence of psychiatric disorders among cancer patients. **Journal of the American Medical Association**, 249:751-757.

Diener, E. 2000. Subjective well-being: The science of happiness, and a proposal for a national index. **American Psychologist,** 55:34-43.

Diner E.,; Suh, E. &; Oishi, S. 1997. Recent findings on subjective well-being. **Indian Journal of Clinical Psychology,** 24(1):25-41.

Dobbie, B. J. 1991. Women's mid-life experience: An evolving consciousness of self and children. **Journal of Advanced Nursing**, 15:825-831.

Dougherty, C. W. 1983. Distraction and sex role as determinant of compliance with a request for help. **Journal of Social Psychology**, 119:31-36.

Dubow, E. F. & Tisak, J. 1989. The relation between stressful life events adjustment in elementary school children: The role of social support and social problem-solving skills. **Child Development**, 60:1412-1423.

Dudley, J. R., & Helfgott, C. 1990. Exploring a place for spirituality in the social work curriculum. **Journal of Social Work Education**, 26(3):287-294.

Durkheim, E. 1915. **The Elementary Forms of Religious Life**. New York: Free Press.

Eckenrode, J. (ed.). 1991. **The Social Context of Coping**. New York: Plenum Press.

Ekedahl, M. A. 2002. **Hur Orkar Man i Det Svåraste?: Copingprocesser Hos Sjukhussjälavårdare i Möte Med Existentiell Problematik: En Religionspsykologisk Studie (**How can you bear the challenge of working at the edges of life and death? Coping processes with hospital chaplains encountering existential confrontation: A study in psychology of religion**).** Uppsala: Acta Universitatis.

Elkins, D., Anchor, K. N. & Sandler, H. M. 1979. Relaxation training and prayer behavior as tension reduction techniques. **Behavioral Engineering,** 5:81-87.

Ellison, C. G. 1991. Religious involvement and subjective well-being. **Journal of Health and Social Behavior**, 32-80-90.

Ellison, C. G. 1994. Religion, the life stress paradigm, and the study of depression. In J. S. Levin (ed.), **Religion in Aging and Health: Theoretical foundations and Methodological Frontiers,** 78-121. London: Sage Publications.

Emblen, J. 1992. Religioin and spirituality defined according to current use in nursing literature. **Journal of Preofessional Nursing,** 8:41-47.

Emmons, R. A. 1999. **The Psychology of Ultimate Concerns: Motivation and Spirituality in Personality**. New York: Guilford.

Epstein. G. 1989. **Healing Visualizations: Creating Health Through Imagery**. New York: A Bantam Book.

Feher, S. & Maly, R. C. 1999. Coping with breast cancer in later Life: The role of religious faith. **Psycho-oncology,** 8:408-416.

Ferraro, K. F. & J. R. Koch. J. R. 1994. Religion and health among black and white adults: Examining social support and consolation. **Journal for the Scientific Study of Religion,** 33:362-375.

Fobair, P. 1998. Cancer support groups and group therapies. In K. Ell & J. Williams (eds.), **Advances in Mental Health Research,** 365-398. Washington DC: NASW Press.

Foley, L. S.,Wagner J, Waskel S. A. 1998. Spirituality in the lives of older women. **Journal of Women & Aging**, 10(2):85-91.

Folkman, S. & Lazarus, R. S. 1980. An analysis of coping in a middle-aged community sample. **Journal of Health and Social Behavior,** *21:*219-239.

Folkman, S. & Lazarus, R. S. 1991. Coping and emotion. In A. Monat & R. S. Lazarus (eds.), **Stress and Coping: an Anthology,** 207-227. New York: Columbia University Press.

Forbes, E. J. 1994. Spirituality, aging, and the community-dwelling caregiver and care recipient. **Geriatr Nurs,** 15(6):297-302.

Fournier, J. 2000. Mind over matter. **Health and Fitness,** 13.

Fowler, J. W. 1981. **Stages of Faith**. San Francisco: Harper and Row.

Freud, S. 1961. **The Future of an Illusion**. New York: Norton.

Friedman, T., Slayton, W. B., Allen, L. S., Pollock, B. H., Dumont-Driscoll, M., Mehta, P. & Graham-Pole, J. 1997**.** Use of alternative therapies for children with cancer. **Pediatrics (**electronic article)**,** 100(6):1.

Fromm, E. 1950. **Psychoanalysis and Religion**. New Haven: Yale University Press.

Gall, T. L., Miguez de Renartat, R. M. & Boonstra, B. 2000. Religious resources in long-term adjustment to breast cancer. **Journal of Psychosocial Oncology**, 18(2):21-37.

Ganzevoort, R. R. 1998. Religious coping reconsidered (part two): A narrative reformulation. **Journal of Psychology and Theology,** 26(3):276-286.

Gardner, J. W. & Lyon, J. L. 1982. Cancer in Utah Mormon Men by Lay Priesthood Level. **American Journal of Epidemiology**, 116:243-257.

Gawain, S. 1995. **Creative Visualization**. Novato: New World Library.

Geertz, C. 1966. Religion as a cultural system. In M. Banton (ed.), **Anthropological Approaches to the Study of Religion,** 1-48. London: Tavistock.

Gioiella, M. E., Berkman, B. & Robinson, M. 1998. Spirituality and quality of life in genycologic oncology patients. **Cancer Practice**, 6(6): 333-338.

Glock, C. Y. & Stark, R. 1965. **Religion and Society in Tension**. New York: Rand McNally.

Golafshani, N. 2003. Understanding reliability and validity in qualitative research**. The Qualitative Report,** 8 (4):597-607. Retrieved from http://www.nova.edu/ssss/QR/QR8-4/golafshani.pdf.

Goldberg, R. S. 1990. The transpersonal element in spirituality and psychiatry. **The Psychiatric Residents Newsletter,** 10:9.

Gotay, C. C. 1985. Why me? Attributions and adjustment by cancer patients. **Social Science and Medicine**, 20:825-831.

Greer, S. A. & Watson, M. 1987. Mental adjustment to cancer: Its measurement and prognostic importance. **Cancer Surveys,** 6 (3):439-53.Greer, S. A. & Watson, M. 1987. Mental adjustment to cancer: Its measurement and prognostic importance. **Cancer Surveys,** 6(3):439-53.

Grosseholtforth, M., Pathak, A., Koenig H. G., Cohen, H. J., Pieper, C. F. & Vanhook. 1996. Medical illness, religion, health control and depression of institutionalized medically ill veterans in long-term care. **International Journal of Geriatric Psychiatry,** 11(7):613-620.

Gurin, G., Veroff, J. & Feld, S. 1960. **Americans View Their Mental Health: A Nationwide Interview Survey**. New York: Basic Books.

Gustavsson, A. (ed.). 1985. **Religiösa Väckelserörelser i Norden Under 1800- och 1900-Talen Aktuell Forskning Presenterad vid Ett Symposium** (Religious Revivalist Movement in Nordic Countries During the Nineteenth and Twentieth centuries, Current Research Presented in A Symposium)**.** Paper presented at the symposium "Religious Revival Movements in the Nordic Countries during the Nineteenth and Twentieth centuries". Centrum för religionsetnologisk forskning, Lund.

Hall, G. S. 1904. **Adolescence: Its Psychology and Its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion, and Education (2 vol)**. New York: Appleton.

Halman, L. & Easter, P. 1991. **Trends in Individualization in Western Europe, North America, and Scandinavia: Divergence or Convergence of Underlying Values**. Paper presented in the symposium "Growing into the Europe", Stockholm.

Halman, L. 1994. Scandinavian values: How special are they? In T. Pettersson & O. Riis (eds.), **Scandinavian Values. Religion and Morality in the Nordic Countries,** 59-84. Acta Universitatis Uppsaliensis. Uppsala.

Hamberg, E. 1994. Secularization and value change in Sweden. In T. Pettersson & O. Riis (eds.), **Scandinavian Values: Religion and Morality in the Nordic Countries**, 179-195. Uppsala: Acta Universitatis Uppsaliensis.

Hammar, K. G. 2000. **Ecco Homo: Efter Tvåtusen** (Ecco-homo: after the year two thousand). Stockholm: Verbum.

Hanser,, S. B. & Thompson, L. W. 1994. Effects of a music therapy strategy on depressed older adults. **Journal of Gerontology: Psychological Sciences,** 49:265-269.

Hathaway, W. L. & Pargament, K. I. 1990. Intrinsic religiousness, religious coping, and psychosocial competence: A covariance structure analysis. **Journal for the Scientific Study of Religion,** 29:423-441.

Heinschel, J. A. 2002. Descriptive study of the interactive guided imagery experience. **Journal of Holistic Nursing,** 20:325–347.

Helco, H. & Madsen. H. 1987. **Policy and Politics in Sweden**. Philadelphia: Temple University Press.

Helminiak, D. A. 1987. **Spiritual Development: An Interdisciplinary Study**. Chicago: Loyola University Press.

Herlitz, G. 1995. **Swedes: What We Are Like and Why We Are As We Are.** Uppsala: Uppsala Publishing House AB.

Heim E., Augustiny, K. F., Shaffner, L., & Valach, L. 1993. Coping with breast cancer over time and situation. **Journal of Psychosomatic Research**, 37:523-542.

Highfield, M. F. 1992. Spiritual health of oncology patients: Nurse and Patient Perspectives. **Cancer Nursing**, 15(1):1-8.

Hill, P. C. & Pargament K. I. 2003. Advances in conceptualization and measurment of religion and spiritulity. Implications for physical and mental helath research. **American Psychologist**, 58(1): 64-74.

Hilliard, R. E. 2003. The effects of music therapy on the quality and length of life of people diagnosed with terminal cancer. **Journal of Music Therapy**, 40(2):113-137.

Hobfoll, S. E. 1988. **The Ecology of Stress**. Washington, DC: Hemisphere.

Holahan, C. J. & Moos, R. H. 1987. Risk, resistance, and psychological distress: A longitudinal analysis with adults and children. **Journal of Abnormal Psychology**, 96:3-13.

Hungelmann, J., Kenkel-Rossi, E., Klassen, L. & Stollenwerk, R. 1996. Focus on spiritual well-being: Harmonious interconnectedness of mind-body–spirit- use of the JARL spiritual well-being scale. **Geriatric Nursing,** 17:262-266.

Hussey, D. L. & Layman, D. 2003. Music therapy with emotionally disturbed children. **Psychiatric Times,** XX 8(6).

James, W. 1902/1961. **The Varieties of Religious Experience**. New York: Collier.

Jeffner, A. 1988. **Livsåskådningar i Sverige: Inledande Projektpresentation och Översiktlig Resultatredovisning** (Outlooks on life in Sweden: Introductory project presentation and overview of the results). Uppsala: Tros- och livsåskådningsvetenskap, Univ.

Jenkins, R. A. & Pargament K. I. 1995. Religion and spirituality as sources for coping with cancer. **Journal of Psychosocial Ontology**, 13 (1-2):51-74.

Jenkins, R. A. & Pargamnet, K. I. 1988. Cognitive appraisals in cancer patients. **Social Science and Medicine,** 26:625-633.

Johannisson, K. 1984. Det sköna i det vilda. (The beauty in the wild nature). In Frängsmyr, T. (red.), **Paradiset och Vildmarken** (The Paradise and the Wild Region). Stockholm: LiberFörlag.

Johnson, P. E. 1959. **Psychology of Religion.** Nashville: Abingdon Press.

Johnson, S. C. & Spilka, B. 1991. Coping with breast cancer: The roles of clergy and faith. **Journal of Religion and Health**, 30:21-33.

Kaczorowski, J. M. 1998. Spiritual well-being and anxiety in adults diagnosed with cancer. **Hospice Journal**, 5(3/4):105-116.

Kaldestad, E. 1996. The empirical relationships between standardized measures of religiosity and personality mental health. **Scandinavian Journal of Psychology**, 37(2):205-220.

Kallenberg, K. & Bråkenhielm, C. R. & Larsson, G. 1996. **Tro och Värderingar i 90-talets** Sverige (Beliefs and values in the 1990s in Sweden). Örebro: Libris.

Kesselring, A., Dodd, M. J., Lindsey, A. M. & Strauss, A. L. 1986. Attitude of patients living in Switzerland about cancer and its treatment. **Cancer Nursing,** 9(2):77-85.

Kimble, S. H., McFadden, S. H., Ellor, J. W., and Seeber, J. J. (eds.). 1995. **Aging, Spirituality and Religion: A Handbook**. Minneapolis: Fortress Press.

King, M., & Speck, P. & Thomas, A. 1994. Spiritual and religious beliefs in acute illness - Is this a feasible area for study? **Social Science & Medicine,** 38(4):631-636.

Klinger, E. 1977. **Meaning and Void: Inner Experience and the Incentives in People's Lives**. Minneapolis: University of Minnesota Press.

Knight, W. E. J., & Rickard, N. S. 2001. Relaxing music prevents stress-induced increases in subjective anxiety, systolic blood pressure and heart rate in healthy males and females. **Journal of Music Therapy**, 38:1-17.

Koenig, H. G. 1993. Religion and aging. **Reviews in Clinical Gerontology**, 3(2):195-203.

Koenig, H. G. 1994. Religion and hope for the disabled elder. In J. S. Levin (ed.), **Religion in Aging and Health: Theoretical Foundations and Methodological Frontiers,** 18-51. Thousand Oaks, CA: Sage Publications.

Koenig, H. G. 1995. Religion and health in later life. In M. A. Kimble &, S. H. McFadden (eds.), **Aging, Spirituality and Religion: A Handbook**, 9-29. Minneapolis: Fortress Press.

Koenig, H. G., & McCullough, M. E. & Larson, D. B. 2001. **Handbook of Religion and Health.** New York: Oxford University Press.

Koenig, H. G., Cohen L. K. & Blazer D. G. 1992. Religious coping and depression among elderly, hospitalized medically ill men. **American Journal of Psychiatry,** 149:1693-1700.

Koenig, H. G., Kvale, J. N. & Ferrel, C. 1988b. Religion and well-being in later life. **The Gorontologist**, 28:18-28.

Koenig, H. G., Moberg, D. O. & Kvale L. N. 1988a. Religious activities and attitudes of older adults in a geriatric assessment clinic. **Journal of the American Geriatrics Society,** 36(4):362-374.

Kohn, M. L. 1972. Class, family, and schizophrenia. **Social Forces**, 50:295-302.

Kosmin, B. A., Mayor, E. & Keysar, A. 2001. **American Religious Identification Survey**. The Graduate Center of the City University of New York.

Krause, N. 1993. Coping with cancer. **Western Journal of Nursing Research**, 15(1):31-43.

Krause, N. 1997. Religion, aging, and health: Current status and future prospects. **Journal of Gerontology: Social Sciences**, 52B(6):291-293.

Krout, R. E. 2001. The effects of single-session music therapy interventions on the observed and self-reported levels of pain control, physical comfort, and relaxation of hospice patients. **American Journal of Hospice Palliative Care**, 18(6):383-390.

Kurlychek, R.T. 1976. Level of Belief in Afterlife and Four Categories of Fear of Death in a Sample of 60+ years Old. **Psychological Reports**, 38:22.

Kushner, H. S. 1989. **Who Needs God**. New York: Summit Books.

LaPierre, L. L. 1994. A model for describing spirituality. **Journal of Religion and Helth,** 33:153-161.

Larson, D. B., Pattison, E. M., Blazer, D. G., Omran, A. R. & Kaplan B. H. 1986. Systematic analysis of research on religious variables in four major psychiatric journals, 1976-1982. **American Journal of Psychiatry**, 143:329-334.

Lazarus, R. S. & Folkman, S. 1984. **Stress, Appraisal, and Coping**. New York: Springer.

Lazarus, R. S. & Launier, R. 1978. Stress-related transactions between person and environment. In L. Pervin & M. Lewis (eds.), **Perspectives in Interactional Psychology,** 287–327. New York: Plenum Press.

Levin, J. S. & Markides, K. S. 1986. Religious attendance and subjective health. **Journal for Scientific Study of Religion**, 25:31-40.

Levin, J. S. & Schiller, P. L. 1987. Is there a religious factor in health? **Journal of Religion and Health**, 26:9-36.

Levin, J. S. & Vanderpool, H. Y. 1992. Religious factors in physical health and the prevention of illness. In K. I. Maton & R. E. Hess (eds.), **Religion and Prevention in Mental Health: Research, Vision, and Action,** 83-104. New York: The Haworth Press, Inc.

Levin, J. S. 1988. Religious factors in aging, adjustment, and health: A theoretical overview. **Journal of Religious & Aging**, 4:133-146.

Levin, J. S. 1994. Investigating the epidemiologic effects of religious experience: Finding, explanations, and barriers. In J. S. Levin (ed.), **Religion in Aging and Health: Theoretical foundations and Methodological Frontiers,** 3-17. Thousand Oaks: Sage Publications.

Levin, J. S. 1994. **Religion in Aging and Health: Theoretical Foundations and Methodological Frontiers**. Thousand Oaks: Sage Publications.

Lindén, A. L. 1994. **Människa och Miljö** (Human being and Environment). Stockholm: Carlsson.

Lindenthal, J. J., Myers J. K., Pepper, M. P. & Stein, M. S. 1970. Mental status and religious behavior. **Journal for the Scientific Study of Religion**, 9:143-149.

Lindgren, K. N. & Coursey, R. D. 1995. Spirituality and mental illness: A Two-part study. **Psychosocial Rehabitation Journal,** 18:93-111.

Linn, M. W., Linn, B. S. & Stein S. R. 1982. **Social Science & Medicine**, 16:835-839.

Litwood. R. & Dein, S. 1995. The effectiveness of words: religion and healing among the lubavitch of stamford Hill. **Culture, Medicine and Psychiatry**, 19:339-383.

Loewnthal, K. M., MacLeod, A. K., Goldblatt, V., Lubitsh, G. & Valentine, J. D. 2000. Comfort and joy? Religious, cognition, and mood in Protestants and Jews under stress. **Cognition and Emotion**, 14(3):355-374.

Luckman, T. 1990. Shrinking transcendence, expanding religion? **Sociological Analysis**, 50(2):127-138.

Luckmann, T. 1996. The privatization of religion and morality. In P. Heelas, P., S. Lash & P. Morris (eds.), **Detraditionalization: Critical Reflections on Authority and Identity,** 72–88. Oxford: Blackwell.

Lundmark, M. 2002. ***Bön och Cancer (Pray and Cancer).*** Degree project in religious science studies. Institutionen för religionsvetenskap, Umeå Universitet.

MacLean, C. R. K., Walton, K. G., Wenneberg, S. R., Levitsky, D. K., Mandarino, J. P., Waziri, R., Hillis, S. L. & Schneider R. H. 1997. Effects of the transcendental meditation program on adaptive mechanisms: Changes in hormone levels and responses to stress after 4 months of practice. **Psychoneuroendocrinology,** 22 (4):277-295.

MacReady, W. C. & Greeley, A. M. 1976. **The Ultimate Values of the American Population** (V.23). Beverly Hills: Sage.

Mahoney, A., Pargament, K. L., Murray-Swank, A. & Murray-Swank, N. 2003. Religion and the sanctification of family realtionships. **Review of Religious Research**, 44:220-236.

Maldonado, J. R. 2003. **The Scientific Basis of Spirituality in Healing**. Paper presented in 17th World Congress on Psychosomatic Medicine, Waikoloa, Hawaii.

Marcoen, A. 1994. Spirituality and Personal Well-being in Old Age**. Aging and Society**, 14:521-536.

Marwick, C. 2000. Music therapists chime in with data on medical results. **Journal of the American Medical Association**, 283(6):731-733.

Maslow, A. H. 1964**. Religions, Values and Peak-experiences**. Columbus: Ohio State University Press.

Matthews, D. A., McCullough, M. E., Larson, D. B., Koenig, H. G., Swyers, J. P. & Greenwold Milano, M. 1998. Religious commitment and health status: A review of the research and implications for family medicine**. The Archives of Family Medicine,** 7:118-124.

Mauritzen, J. 1988. Pastoral care for the dying and bereaved. **Death Studies,** 12:111-122.

Mayberry, J. F. 1982. Epidemological Studies of Gastrointestinal Cancer in Christian Sects. **Journal of Clinical Gastroenterology**, 4:115-121.

McAuley, W. J., Pecchioni, L. & Grant, J. A. 2000. Personal accounts of the role of God in health and illness among older rural African American and White residents. **Journal of Cross-Cultural Gerontology,** 15(1):13-35.

McCrae, R. R. 1984. Situational determinants of coping response: Loss, threat, and challenge. **Journal of Personality and Social Psychology**, 46:919-928.

McCulloch, A. W. 1985. **Adjustment to Old Age in a Changing Society**. Southampto: University of Southampton.

McFadden, S. H. 1995. Religion and well-being in aging persons in an aging society. **Journal of Social Issues** 51:161-175.

McFadden, S. H. 1995. Religion and well-being in aging persons in an aging society. **Journal of Social Issues**, 51(2):161-175.

McIntosh, D. & Spilka, B. 1990. Religion and physical health: The role of personal faith and control beliefs. **Research in the Social Scientific Study of Religion**, 2:167-194.

Mehta, K. K. 1997. The impact of religious beliefs and practices on Aging: A cross-cultural comparison. **Journal of Aging Studies**, 11(2):101-114.

Mickley, J. & Soeken, K. 1993. Religiousness and hope in Hispanic and Anglo-American women with breast cancer. **Oncology Nursing Forum**, 20:1171-1177.

Mickley, J., Soeken, K. & Belcher, A. 1992. Spiritual well-being, religiousness and hope among women with breast cancer. **Image - Journal of Nursing Scholarship**, 24:267-272.

Miller, J. B. 1986. **Toward a New Psychology of Women** (2nd ed.). Boston: Beacon Press.

Miller, W. R. & Thoresen, C. E. 2003. Spirituality, religion, and health: An emerging research field. **American Psychologist**, 58:24-35.

Moberg, D. O. 1996. Religion and aging. In J. Johnson & R. Slater (eds.), **Aging and Later Life,** 193-220. London: Sage.

Moberg, D. O. 2002. Assessing and measuring spirituality: confronting dilemmas of universal and particular evaluative criteria. **Journal of Adult Development**, 9:47-60.

Moffitt, L. C. 1997. **Religiosity: A Propensity of the Human Phenotype**. Commack, NY: Nova Science.

Moos, R. H. 1984. Context and coping: Towards a unifying conceptual framework. **American Journal of community Psychology,** 12(5):5-25.

Musick, M. A., Koenig, H. G., Cohen, H. & Hays. J. C. 1998. Religious activity and depression among community-dwelling elderly persons with cancer: the

moderating effect of race. **Journals of Gerontology (Series B): Psychological Sciences and Social Sciences**, 53(4):218-227.

Neighbors, H. W., Jackson J. S., Bowman P. J & Gurin G. 1983. Stress, coping, and Black mental health: Preliminary findings from a national study. **Prevention in Human Services,** 2(3):5-29.

Norris, F. H. & Murrell, S. A. 1988. Prior experience as a moderator disaster impact on anxiety symptoms in older adults. **American Journal of Community Psychology**, 16:665-683.

O'Callaghan, C. 2004. Identifying comparable therapeutic foundations between "musical re-play" and improvisation: Cancer research inspires a hybrid perspective. **Nordic Journal of Music Therapy,** 13(2).

Ochs, C. 1996. **Women and Spirituality**. Lanham, MD: Rowman and Littlefield.

Paloutzian, R. F. 1981. Purpose in life and value changes following conversion. **Journal of Personality and Social Psychology**, 41:1153–1160.

Pargament, K. I. & Hahn, J. 1986. God and the just world: Causal and coping attributions to God in health situations. **Journal for the Scientific Study of Religion**, 25:193-207

Pargament, K. I. & Mahoney, A. 2005. Sacred matters: Sanctification as a vital topic for the psychology of religion. **The International journal for the Psychology of Religion**, 15(3):179-198.

Pargament, K. I., Koenig, H. G. & Perez, L. M. 2000. The many methods of religious coping: Developmnet and initial variation of the RCOPE. **Journal of Clinical Psychology**, 56(4):519-543.

Pargament, K. I. 1999. The psychology of religion and spirituality? Yes or no. **International journal for the Psychology of Religion,** 9:3-16.

Pargamnent , K. I., Zinnbauer, B. J., Scott, A. B., Butter, E. M., Zerowin, J. & Stanik, P. 1998. Red flags and religious coping: Identifying some religious warning signs among people in crisis. **Journal of Clinical Psychology**, 54:77-89.

Pargament, K. I. 1997. **The Psychology of Religion and Coping: Theory, Research, Practice**. New York: Guilford Press.

Pargament, K. I. & Park, C. L. 1995. Merely a defense? The variety of religious means and ends. **Journal of Social Issues,** 51(2):13-32.

Pargament, K. I., Van Haitsma, K. S. & Ensing, D. S. 1995. Religion and coping. In S. H. Kimble, S. McFadden, J. W. Ellor, & J. J. Seeber (eds.), **Aging, Spirituality and Religion: A Handbook,** 111–128. Minneapolis: Fortress Press.

Pargament, K. I., Ensing, D., Falgout, K., Olsen, H., Reilly, B., Van Haitsma, K. & Warren, R. 1990. God help me (I.): Religious coping efforts as predictors of the outcomes to significant negative life events. **American Journal of Community Psychology**, 18:793-824.

Pargament, K. I., Kennell, J., Hathway, W., Grevengoed, N., Newman, J. & Jones, W. 1988. Religion and the problem-solving process: Three styles of coping**. Journal for the Scientific Study of Religion**, 27:90-104.

Pargament, K. I., Steele, R. E. & Tyler, F. B. 1979. Religious participation, religious motivation and individual psychosocial competence. **Journal for the Scientific Study of Religion,** 18:412-419.

Pastorello, T. & Wright E. 1997**. Spirituality, Social Work and Aging**. Paper presented at the Association for Gerontology in Higher Education (AGHE) conference, Boston, MA.

Peabody, D. 1985. **National Characteristics**. New York: Cambridge University .

Peterson, C., Seligman, M. E. P. & Vaillant, G. E. 1988. Pessimistic explanatory style is a risk factor for physical illness: A thirty-five year longitudinal study . **Journal of Personality and Social Psychology,** 55:23-27.

Pettersson, T. & Riis, O. (eds.). 1994. **Scandinavian Values. Religion and Morality in the Nordic Countries**. Uppsala: Acta Universitatis Uppsaliensis.

Pettersson, T. 2000. Svenskan och religionen. In L. Lewin (ed.), **Svenskt Kynne**. Uppsala: Acta Universitatis Upsaliensis.

Phillips III, R. E., Pargament, K. I., Lynn, Q. K. & Crossley, C. D. 2004. Self-directing religious coping: A deistic God, abandoning God, or no God at all? 2004. **Journal for the Scientific Study of Religion**, 43(3):409-418.

Pieper, J. Z. T. & Uden, M. H. F. van. 2001. **Geesteljke verzorging op de Fontein : Ondersoek onder clienten van de Fontein naar hun geloof en hun behoefte ann geestelijke verzorging** (Pastoral care at "De Fontein". A study of de Fontein's clients and their needs of pastoral care). Utrech: De Fontein.

Pollner, M. 1989. Divine relations, social relations, and well-being. **Journal of Health and Social Behavior**, 3:92-104.

Poloma, M. M. & Pendleton, B. F. 1989. Religious domains and general well-being. **Social Indicators Research**, 22:1-22.

Pressman, P., Lyons, L. S., Larson D. B. & Strain J. J. 1990. Religious belief, depression and ambulation status in elderly women with broken hips. **American Journal of Psychiatry**, 147:758-760.

Reinharz, S. & Rowles, G. D. 1988. **Qualitative Gerontology**. New York: Springer Publishing Company.

Richards, P. S. & Bergin, A. E. 1997. **A Spiritual Strategy for Counseling and Psychotherapy**. Washington, Dc.: APA Books.

Rifkin, A., Doddi, S., Karagji, B. & Pollack, S. 1999. Religious and other predictors of psychosocial adjustment in cancer patients. **Psychosomatics,** 40(3):251-256.

Riis, O. 1992. **Secularization in Scandinavia**. Paper for the Nordic conference for the Sociology of Religion. Skálholt, Iceland.

Riis, O. 1994. Patterns of secularization in scandinavvia. In T. Pettersson & O. Riis (eds.), **Scandinavian Values. Religion and Morality in the Nordic Countries,** 99-128. Uppsala: Acta Universitatis Uppsaliensis.

Riner, R. 1999. Guided imagery and other forms of alternative medicine - Trend or aberration? Where does it Fit in Your Practice? **The Journal of Invasive Cardiology,** 11(4):263-264.

Risberg, T., Wist, E., Kaasa, S., Lund, E. & Norum, J. 1996. Spiritual healing among Norwegian hospitalised cancer patients and patients' religious needs and preferences of pastoral services. **European Journal of Cancer**, 32A(2):274-281.

Roberts, J. A., Brown, D., Elkins, T. & Larson, D. B. 1997. Factors influencing views of patients with gynecologic cancer about end-of-life decisions. **American Journal of Obstetrics and Gynecology,** 176(1 Pt 1):166-172.

Rosenbaum, E. H. & Rosenbaum, I. R. 2001. **Supportive Cancer Care: The Complete Guide for Patients and Families.** Naperville, Ill: Sourcebooks Inc.

Rosik, C. H. 1989. The impact of religious orientation in conjugal bereavement among older adults. **International Journal of Aging and Human Development,** 28(4):251-260.

Rubin, Z. & Peplau, L. A. 1975. Who believes in a just world? **Journal of Social Issues**, 31(3):65-90.

Ruffingrahal, M. A. & Anderson, J. 1994. Factors associated with qualitative well-being in older women. **Journal of Women & Aging**, 6(3):3-18.

Runblom, H. 1998. Sweden as a Multicultural Society**. Current Sweden Series 418.** Swedish Institute online publishing.

Rushton, J. P. 1989. Genetic similarity, human altruism, and group selection. **Behavioral and Brain Sciences**, 12:503-559.

Rutledge, J., & Spilka, B. 1993. **Coping with Intimacy: A Problem for the Single Adult Mormon.** Paper presented at the meeting of the American Psychological Association, Toronto.

Ryshlak, J. E. 1981. **Introduction to Personality and Psychotherapy**. Boston: Houghton-Mifflin.

Sahler, O. J., Hunter, B. C. & Liesveld, J. L. 2003. The effect of using music therapy with relaxation imagery in the management of patients undergoing bone marrow transplantation: A pilot feasibility study. **Alternative Therapies in Health & Medicine**, 9(6):70-74.

Sammon, T. J. 1997. A piece of my mind: March music. **Journal of the American Medical Association**, 275(10):816.

Sarason, S. B. 1993. American psychology, and the needs of transcendence and community. **American Journal of Community Psychology**, 21:185-202.

Schaefer, C. A. & Gorsuch, R. L. 1993. Situational and personal variations in religious coping. **Journal for the Scientific Study of Religion**, 32 (2):136-147.

Schaie, K. W., Krause, N. & Booth, A. (eds.). 2004. **Religious Influences on Health and Well-Being in the Elderly**. New York: Spring Publishing Company.

Scott, E. R. 1998. **Spiritual Well-being and Religious Practice of Older People in Residential Care**. MSc Life Course Development. University of London. Birkbeck college.

Seale, C. 1999. Quality in qualitative research. **Qualitative Inquiry**, 5(4):465-478.

Sears, S. F. & Greene, A. F. 1994. Religious coping and the threat of heart transplantation. **Journal of Religion and Health**, 33:221-229.

Seeman, T. E., Dubin, L. F. & Seeman, M. 2003. Religiosity/spirituality and health: A critical review of the evidence for biological pathways. **American Psychologist**, 58:53-63.

Sevigny, A. 2005. BC teen ordered to get treatment despite religious objections. **National Review of Medicine** 2 (10). Retrieved from: http://www.nationalreviewofmedicine.com/issue/2005/05_30/2_government_medicine01_10.html.

Shafer, K. & Greenfield, F. 2000. **Asthma Free in 21 Days: The Breakthrough Mindbody Healing Program.** New York: HarperCollins

Shafranske, J. F. (ed.). 1996. **Religion and the Clinical Practice of Psychology**. Washington, Dc: APA Books.

Shrimali, S. & Broota, K. D. 1987. Effect of surgical stress on belief in God and superstition: An in situation investigation. **Journal of Personality and Clinical Studies**, 3:135-138.

Smith, C. S. & Gorsuch, R. L. 1989. Sanctioning and causal attributions to God: A function of theological Position and actors' characteristics. In M. L. Lynn & D. O. Moberg (eds.), **Research in the Social Scientific Study of Religion** (vol 1), 133-152. Greenwich, CT: JAL Press.

Smith, M. B. 1966. Explorations in competence: A study of pace corps teachers in Ghana. **American Psychologist**, 21:556-566.

Smith, M; Casey, L., Johnson, D., Gwede, C. & Riggin, OZ. 2001. Music as a therapeutic intervention for anxiety in patients receiving radiation therapy. **Oncology Nursing Forum,** 28(5):855-866.

Spencer, J. & Jacobs, J. (ed.). 1998. **Complementary and Alternative Medicine: An Evidence Based Approach**. Philadelphia, PA: Mosby Yearbooks.

Spiegel, D. & Bloom J. R. 1983. Group therapy and hypnosis reduce metastatic breast carcinoma pain. **Psychosomatic Medicine,** 45:333-339.

Spiegel, D. & Moore, R. 1997. Imagery and hypnosis in the treatment of cancer patients. **Oncology**, 11(8):1170-1195.

Spilka, B. & Schmidt, G. 1983. General attribution theory for the psychology of religion: The influence of event-character on attributions to God. **Journal for the Scientific Study of Religion**, 22:326-329.

Spilka, B., Hood, R. & Gorsuch, R. L. 1985. **The Psychology of Religion: An Empirical Approach.** Englewood Cliffs, Nj: Prentic-Hall.

Spilka, B., Spangler, J. D. & Nelson, C. B. 1983. Spiritual support in life threatening illness. **Journal of Religion and Health,** *2:*98–104.

Standley, J. 2000. Music research in medical/dental treatment: An update of a prior meta-analysis. In C. Furman (ed.), **Effectiveness of Music Therapy Procedures. Documentation of Research and Clinical Practice**, 1-64. Silver Springs, MD: American Music Therapy Association.

Starbuck, E. D. 1899. **The psychology of Religion**. New York: Scribner.

Stark, R. & Hamberg, E. & Miller A. S. 2005. Exploring spirituality and unchurched religions in America, Sweden, and Japan. **Journal of Contemporary Religion,** 20(1):3-23.

Stenbacka, C. 2001. Qualitative research requires quality concepts of its own. **Management Decision**, 39(7):551-555.

Stone, M. 1976. **When God Was a Woman**. New York: Harcourt Brace Jovanovich

Strauss, A. & Corbin, J. 1990. **Basics of Qualitative Research: Grounded Theory Procedures and Techniques**. Newbury Park, CA: Sage Publications.Strízenec, M. 2000. Religion and coping: empirical verification of their interaction. **Studia Psychologica**, 42:1-2.

Sundin, B. 1981. Från riksparken till bygdemuseum. Om djurskydds-, naturskydds- och hembygsrörelserna i sekelskiftets Sverige (From national park to rural community museum. On prevention of cruelty to animals -, environment protection -and rural community movements in Sweden at the turn of the century). In **Naturligtvis.** 14. Uppsatser om natur och samhälle tillägnade Gunnar Eriksson. Umeå : Inst. för idéhistoria, Umeå Univ.

Sundback, S. 1994. Nation and gender reflected in Scandinavian religiousness. In T. Pettersson & O. Riis (eds.), **Scandinavian Values. Religion and Morality in the Nordic Countries**, 129-150. Acta Universitatis Upsaliensis.

Tarakeshwar, N., Stanton, J. & Pargament, K. I. 2003. Religion: An overlooked dimension in cross-cultural psychology. **Journal of Cross-Cultural Psychology**, 34:377-394.

Tart, C. 1983. **Transpersonal Psychologies**. El Cerrito, CA: Psychological Process Inc.

Tart. C. 1975. Introduction. In C. T. Tart (eds.), **Transpersonal Psychologies,** 3-7. New York: Harper and Row.

Taylor, E. B. 1968. The science of culture. In M. H. Fried (ed.), **Readings in Anthropology: Cultural and Anthropology,** 2:1-18. New York: Thomas Y. Crowell.

Thomas, L. E. 1997a. Late-life effect of early mystical experiences: A cross-cultural comparison. **Journal of Aging Studies**, 11(2):101-114.

Thomas, L. E. 1997b. **The Job Hypothesis: Gerotranscendence and life satisfaction among elderly Turkish Moslems**. Paper presented at 50th Annual Scien-

tific Meeting, The Gerontological Society of America, Cincinnati, USA, 17 november, 1997.

Tilch, S., Haffa-Schmidt, U., Wandt, H., Kappauf, H., Schafer, K., Birkmann, J. & Gallmeier W. M. 1999. Supportive music therapy improves mood state in patients undergoing myeloablative chemotherapy. **Bone Marrow Transplant,** 23:170.

Torbjørnsen, T., Stifoss-hanssen, H., Abrahamsen, A. F. & Hannisdal, E. 2000. **Kreft og Religiositet- En Etterundersøkelse av Pasienter med Hodgkins Syndom** (Cancer and religosityreligiosity: A follow-up study of patients with Hodgkins Hodgkin's syndrome). Tidsskr Nor Lægeforen, 3:346-348.

Tornstam, L. 1989. Gero-transcendence: A reformation of the disengagement theory. **Aging: Clinical and Experimental Research**, 1(1):56-63.

Tornstam, L. 1994. Gero-Transcendence: A theoretical and empirical exploration. In L. E. Thomas & S. A. Eisenhandler (eds.), **Aging and The Religious Dimension**, 203-225. Westport: Greenwood Publishing Group.

Tornstam, L. 1996. Gerotranscendence: A theory about maturing into old age. **Journal of Aging and Identity,** 1:37-50.

Tornstam, L. 1997a. Gerotranscendence: The contemplative dimension of aging. **Journal of Aging Studies**, 2(2):143-154.

Tornstam, L. 1997b. Gerotranscendence in a broad cross sectional perspective. **Journal of Aging and Identity**, 2(1):17-36.

Tornstam, L. 1997c. Life crises and gerotranscendence. **Journal of Aging and Identity,** 2:117-131.

Tornstam, L. 2005. *Gerotranscendence: A Developmental Theory of Positive Aging.* New York: Springer Publishing Company.

Tyler, F. B. 1978. Individual psychosocial competence: A personality configuration. **Education & Psychological measurements,** 38:309-323.

Uddenberg, N. 1995. **Det Stora Sammanhanget. Moderna Svenskars Syn på Människans Plats i Naturen** (The great whole: The modern Swede's view of the human beings' place in nature). Lund: Nya Doxa.

Vaughan, F. 1991. Spiritual issues in psychotherapy. **Journal of Transpersonal Psychology**, 3:435-444.

Vinokur, A. D., Threatt, B. A., Caplan, R. d. & Zimmerman, B. L. 1989. Physical and psychosocial functioning and adjustment to breast cancer: Long-term follow-up of screening population. **Cancer,** 63:394-405.

Vogel, L. J. 1995. Spiritual development in later life. In M. A. Kimble, S. H. McFadden, J. W. Ellor & J. J. Seeber (eds.), **Aging, Spirituality, and Religion,** 74-86. Minneapolis: Fortress Press.

Wager, E. 2001. Intresset för alternativa behandlingsmetoder ökar i Sverige. **Skandinavien Direct,** 10:16-17.

Wallis, C. 1996. Faith and healing. **Time,** 147(26):58-64.

Weber, M. 1964. **The Sociology of Religion**. Boston:Beacon Press.

Weber, S., Nuessler, V. & Wilmanns, W. 1997. A pilot study on the influence of receptive music listening on cancer patients during chemotherapy. **International Journal of Arts Medicine,** 5(2):27-35.

Weisman, A. D. & Worden, J. W. 1976. The existential plight in Cancer: Significance of the first 100 days. **International Journal of Psychiatry and Medicine**, 7:1-15.

Welch, M. R. & Barrish, J. 1982. Bringing religious motivation back in: A multivariate analysis of motivational predictors of student religiosity. **Review of Religious Research,** 23(4):357-369.

Wheaton, B. 1983. Stress, personal coping resources, and psychiatric symptoms: An investigation of interactive models. **Journal of Health and Social Behavior**, 24:208-229.

Wheeler, B. L. 2003. First international symposium on music therapy training: A retrospective examination? **Nordic Journal of Music Therapy,** 12(1):54-66.

Wicks, J. W. 1990. **Greater Toledo Area Survey**. Bowling Green, Ohio: Population and Society Research Center.

Wikström, O. 1998. The centripetal journey: Individualized religion in Sweden as a defense against plurality. **Current Dialogues**, 32:12-19.

Williams, D. R. 1994. The measurement of religion in epidemiologic studies. problems and prospects. In J. S. Levin (ed.), **Religion in Aging and Health: Theoretical Foundations and Methodological Frontiers,** 125-148. Sage Publications.

Winter, G. 2000. A comparative discussion of the notion of 'validity' in qualitative and quantitative research. **The Qualitative Report**, 4(3&4). Retrieved from: http://www.nova.edu/ssss/QR/QR4-3/winter.html.

Wong-McDonald, A. & Grouch, R. L. 2000. Surrender to God: An additional coping style? **Journal of Psychology and Theology**, 28(2):149-161.

Woodhead, L. & Heelas, P. (eds) . 2000. **Religion in The Modern Times**. Malden: Blackwell Publishers.

Wyatt, G. K., Friedman, L. L., Given, C. W., Given, B. A. & Christensen, K. 1999. Complementary therapy use among older cancer patients. **Cancer Practice**, 7(3):136-144.

Yates, J. W., Chalmer, B. J., St. James, P., Follansbee, M. & McKegney, F. P. 1981. Religion in patients with advanced cancer. **Medical and Pediatric Ontology**, 9:121-128.

Zinnbauer, B. J. & Pargamnet, K. I. 2005. Religiousness and spirituality. In R. F. Paloutzian & C. L. Parks (eds.), **Handbook of psychology and religion,** 21-42**.** New York: The Guilford Press.

Zinnbauer, B. J. & Pargamnet, K. I., & Cole, B., Rye, M., Butter, E. M., Belavich, T. G., Hipp, K., Scott, A. B. & Kadar, J. L. 1997. Religion and spirituality: Unfuzzying the fuzzy. **Journal for the Scientific Study of Religion**, 36(4):549-564.

Zinnbauer, B. J., & Pargamnet, K. I. & Scott, A. B. 1999. The emerging meaning of religiousness and spirituality: problems and prospects. **Journal for Personality,** 67(6):889-919(31).

Zuckerman, D. M., Kasl, S. V. & Ostfield A. M. 1984. Psycholsocial Predictors of Mortality among the Elderly Poor. **American Journal of Epidemiology,** 119:410-423.

Others references:

American Academy of Pediatrics. 1997. Religious objections to medical care. **Pediatrics,** 99(2):279-281

Psychological Aspects of Breast Cancer Study Group. 1987. Psychological response to mastectomy: A perspective comparison study. **Cancer,** 59:1-26.

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